Residency Description

PSY-R8306 - Intervention: Case Formulation (non-credit). This face-to-face residency course is focused on forming case conceptualizations using various theoretical approaches. Learners apply theory to better understand a client’s current issues and identify how these issues developed and are sustained. Learners also discuss the strengths and limitations of the various theories when applied to a diverse set of clients and client issues.

This residency class is associated with PSY8310, Theories of Psychotherapy.

Residency Objectives

By successfully completing this course, students will have demonstrated their ability to:

1. Initiate clinical interviews, build effective relationships, and appropriately consider cultural and individual differences with a diverse set of clients. **GOCs 1.1.1, 1.1.2, 4.1.1, 4.1.2**
2. Gather and utilize a full range of current and historical information, to formulate appropriate diagnoses and effective case conceptualizations. **GOCs 4.1.3, 4.2.1, 4.2.2**
3. Incorporate a thorough understanding and sensitivity to ethical concerns in all case conceptualizations. **GOCs 2.1.1, 2.1.2**
4. Articulate the strengths and limitations of various psychological theories when applied to a diverse set of clients and client issues. **GOCs 3.2.1, 3.3.1**
5. Articulate and defend their preferred theoretical orientation. **GOCs 4.2.3, 4.3.1**
6. Apply appropriate theoretical models to enrich case conceptualizations. **GOCs 4.2.3**
7. Apply professional competencies associated with successful training and practice of psychology. **GOC 1.3.1, 1.3.2, 1.3.3, 1.3.4, 1.3.5**

Course Materials

- DSM 5 website for online assessment measures: http://www.psychiatry.org/dsm5
- Handouts from PSY8000

Course Requirements

1. Full attendance throughout the residency.
2. Participation in all learning activities.
3. Completed outcome documentation.
4.

**Personal Disclosure**
To provide the best learning experience, the residencies encourage students to participate in experiential exercises and discussion topics that may include disclosure of information that is personal. Students are asked to use their best judgment to determine what is appropriate involvement and disclosure. Students are always welcome to decline to share. Also, to provide the most conducive learning environment, we request that you keep confidential all the personal material that is shared in the residencies.

**Americans with Disabilities Act**
Students with an ADA disability on file with Capella University should communicate with the Director of Residency Training and the faculty instructor prior to the beginning of this residency about any accommodations needed to allow the student to demonstrate competence in skills of this residency.

**Course Schedule and Learning Activities**

**Day 1**

1 hour **Welcome and Introductions**
The class instructor will welcome students, discuss the course objectives, review previous residencies and engage students in a discussion of their experiences, strengths, and weaknesses. Instructor will provide an overview of case formulations and the topics and activities associated with the current residency. The importance of positive relationships, effective communication, openness to criticism, and self-reflection will be emphasized for the successful completion of this residency. *Residency Objectives 1, 2, 7*

45 min **Presentation of Grand Rounds homework assignment**
Each group will present the case prepared for this WiR from the perspective of the assigned theoretical orientation. Presentations should be no longer than 10 minutes, and will be further addressed in the discussion of the theories in the afternoon. *Residency Objectives 5, 6, 7*

1 hour **Professional Development**
The Director of Clinical Training will meet with the class to discuss practicum placement and to introduce students to the practicum application process.

1 hour 30 min **Theoretical Orientation**
Prior to this residency, students were instructed to read at least one source from each of the three theory groups (Existential/Humanistic; Cognitive/Behavioral, and Psychodynamic). Instructor will lead a discussion of the major tenets of each of these theory groups. Students are expected to actively participate and share what they learned from
the assigned readings and the cases developed for the homework assignment. Students will self-identify with one of the three theory groups and articulate and defend their rationale for this choice in the large group.

*Residency Objective 5, 6, 7*

1 hour 30 min  Case Formulation Exercise I  
**Handouts:** Case Presentations – through conceptualization, Steps to developing a case formulation, Case Scenario 1
Using the self-identified theoretical orientations of each student, the instructor will form three groups and hand out a case. Each group will complete the Level 1 Cross-Cutting Symptom Measures and develop a diagnostic impression and a case conceptualization for the client discussed in the case. Students will engage in a discussion of skills and knowledge learned in previous residency classes and their importance to the development of effective and appropriate case conceptualizations.

Residency Objectives 2, 5, 6, 7

1 hour  Case Formulation Exercise II  
**Handout:** Case Scenario 2
In the same three groups as the previous exercise, a second case scenario will be provided to the students. The instructor will assign a theoretical approach to each group different from what they used in Exercise I and they will again complete the Level 1 Cross-Cutting Symptom Measures and develop diagnostic impressions and a case conceptualization and then present this to the full cohort. Instructor will lead a discussion of the similarities and differences between conceptualizations with different theories as well as a discussion of comfort levels, expertise, and applicability of the various theories to the two cases discussed so far.

Residency Objectives 2, 5, 6, 7

Day 2

1 hour 30 min  Role-Play Exercise I (Part 1)  
In groups of three, students will practice building relationships, gathering relevant information, determining a diagnostic impression, and developing a case conceptualization. In each group, one student will role-play a client of his or her choosing (with guidance from the instructor),
one will play the therapist, and one will observe and take notes and act as a supervisor/consultant as needed. Each role-play will last approximately 15-20 minutes, after which the group members will determine a diagnosis and discuss how one or more theories could be applied to the conceptualization of the case, making sure to consider ethical concerns and issues of diversity. Students will rotate roles until everyone has played each role once. This exercise continues into the next session. 

Residency Objectives 1, 2, 3, 4, 6, 7

45 min  
Role-play Exercise I (Part 2)  
Continuation of previous exercise. 
Residency Objectives 1, 2, 3, 4, 6, 7

30 min  
Role-play Exercise I - Discussion  
In the large group, instructor will lead a discussion of Role-Play Exercise I. Topics to cover include theoretical approaches to conceptualization (which was used most, why was it used the most, which was most difficult to apply, which theory fits which cases better, etc.). Students will discuss how their views of different theories changed as the exercise progressed and what additional information they would like to know about the clients and the theories they applied to the cases. Students will also determine their individual strengths and weaknesses regarding their performance in the role-play exercise. 
Residency Objectives 1, 2, 3, 4, 5, 6, 7

2 hours  
Role-play Exercise II  
Instructor will lead a brief discussion on culture, diversity, individual differences, and bias as it relates to diagnosis and case conceptualization. Following the discussion, instructor will assign students to groups of three where students will practice building relationships, gathering relevant information, determining a diagnostic impression, and developing a case conceptualization in role play scenarios with diverse clientele. In each group, one student will role-play a client of his or her choosing (with guidance from the instructor), one will play the therapist, and one will observe, take notes, and act as a supervisor/consultant, as needed. Each role-play will last approximately 15-20 minutes, after which the group members will determine a diagnosis and discuss how one or more theories could be applied to the conceptualization of the case, making sure to consider ethical concerns and issues of diversity. Students will switch roles so that each plays each role once.

In the discussions, groups should focus on how changes in the client demographics or situation would change the conceptualization of the case. Each group will present one of the role-played cases to the larger group in the next session so some time should be spent organizing this presentation and determining what will be presented and how the case will be conceptualized.
Residency Objectives 1, 2, 3, 4, 5, 6, 7

2 hours
Role-play Exercise II Discussion
Back in the large group, each of the three smaller groups from Exercise II will present one of the cases they role-played. The presentation should last no more than 15 minutes (instructor will stop the group at 15 minutes whether or not they have completed their presentation), followed by a brief (10 minute) discussion. The presentation should focus primarily on background and conceptualization and should follow the model presentation handout. Subsequent discussion should be focused on how well the theory matches the client and the client’s situation, what additional information would be helpful in understanding the client, and what struggles were experienced in using theory to understand the client and in determining the important aspects of the client’s case to present, especially considering real-life time limitations of such presentations.

Once all groups have presented, the instructor will summarize the presentations and lead a discussion on presenting cases and using theory to guide the conceptualization of clients.
Residency Objectives 1, 2, 3, 4, 5, 6, 7

1 hour
Theoretical Debate Preparation
Handout: Case Scenario 3
In the large group, instructor will re-address the mechanics of case presentations as a precursor to treatment planning. The goal of this discussion will be on understanding the client, how theory informs this understanding, and on determining the important aspects of the case to discuss when presenting it to others. Students will then be split into three groups (Existential/Humanistic, Cognitive/Behavioral, and Psychodynamic) and given a case study. Each group will view the case through the lens of their assigned theory, complete the Level 1 Cross-Cutting Symptom Measures, and develop a diagnosis and conceptualization using this theory as the foundation. In the first session on Sunday, each group will present the client as seen through the lens of their assigned theory.
Residency Objectives 3, 4, 5, 6, 7

Day 3

2 hours
Theoretical Debate
Each group will spend no more than 15 minutes presenting the case as seen through the lens of the group’s assigned theoretical orientation. After each presentation, the other two groups will have 10-15 minutes to ask questions, challenge beliefs, ask for clarification, and otherwise critique the theory and case conceptualization. This debate should remain professional and be focused on challenging assumptions, uncovering weaknesses in theory, and gaining a more solid understanding
of the theory and its application to case conceptualization. It should not
be focused on any individual's knowledge or beliefs.

After all three groups have presented and each theory debated, the
instructor will summarize the debate and debrief the students. Students
will discuss which theory matches the client the best and why, as well as
how, this may change if different facts about the case were changed
(such as client race or culture, age, sex, sexual orientation, family
background, etc).

Residency Objectives 3, 4, 5, 6, 7

1 hour 15 min

Lessons Learned and Next Steps
Handout: Homework Assignments
In the large group, students will discuss the weekend, including what they
learned (about case conceptualization, about theory and how it informs
conceptualization, similarities and differences between theories, etc.),
what further learning they need to undertake and what faculty guidance
would be helpful, and what their next steps will be as they progress to the
Treatment Planning weekend. Students should identify their individual
strengths and weaknesses in regard to their performance during this
residency, their knowledge of theory, and their application of theory to
inform case conceptualizations.

As an introduction to the next residency weekend, the instructor will lead a
brief discussion of the importance of theoretical orientation and case
conceptualizations in the development of effective and appropriate
treatment plans and will provide instructions for the homework assignment
due at the beginning of the next residency weekend.

Residency Objectives 3, 4, 5, 6, 7

1 hour 30 min

Completion Activities
Students complete self-assessment Skills Rating Forms and Course
Evaluation materials. Attendance logs are signed and returned to the
instructor. Group and individual feedback will be provided by the
instructor.
Grand Rounds Presentation

As part of each Intervention Week in Residence (WIR), you will be asked to make a group presentation in pairs. Each group will focus on a different theoretical orientation (CBT, Psychodynamic or Humanistic/Existential). Each theoretical orientation should be represented each weekend. The first step is to pick a partner and then decide which theoretical orientation your group will be representing. Be sure to send your proposed partner and theoretical emphasis to your instructor at least 2 weeks prior to the intervention WIR. The instructor will assign a theoretical orientation to your group if not all the orientations are represented. Over the course of the year, you should present from each theoretical orientation at least once and use a different partner for each presentation. We will briefly discuss the presentations at the beginning of the WIR.

Prior to the weekend, you should have prepared your presentation. This presentation should meet the following characteristics:

- 15-20 total minutes including discussion
- Provide an overview of the theory, applying it to the weekend’s topic (5 minutes)
- Describe how this theory is applied to a specific case example (5 minutes)
- Discussion (5-10 minutes)
- Include reference list from refereed journals for distribution for each weekend

Presentations will be a part of the following weekends:

- Intervention: Diagnostic Interviewing
- Intervention: Case Presentation
- Intervention: Treatment Planning
- Intervention: Case Formulation
- Crisis Intervention and Risk Assessment
- Practice of Psychotherapy
- Residency Capstone: Supervision, Consultation, and Advocacy
### STUDENT SKILLS RATING FORMS

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<tr>
<td>Nature of Person</td>
<td>Psychoanalytic/Psychodynamic</td>
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<tr>
<td>Childhood experiences shape later behavior; people are largely determined by early experiences.</td>
<td>People learn through reinforcement of behaviors; thoughts and beliefs shape feelings and behaviors.</td>
</tr>
<tr>
<td>Important developmental factors</td>
<td>Psychosexual stages; Erikson’s stages of development; early attachment associated with later relationships.</td>
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<tr>
<td>Ideas about pathology/disorder</td>
<td>Unhealthy early situations cause fixation, neurosis, anxieties. Poor early attachment linked to later problems. “Root” problem—symptoms.</td>
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<tr>
<td>Nature of change</td>
<td>Releasing “energy” that was tied up in fixations allow personal growth and transformation. Reparative relationships allow growth. Gaining insight allows for changes and alternative choices.</td>
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<tr>
<td>What does “better” look like?</td>
<td>Patient gains insight about root of problem; this can lead to repair of childhood problems. Person is able to work and to love.</td>
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<td>Core factors, concepts</td>
<td>Defense mechanisms; psychosexual stages; id, ego, superego; Unconscious; dream interpretation; transference, countertransference; importance of relationships.</td>
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<td>Types of approaches</td>
<td>Object Relations; Ego Psychology; Interpersonal Tx; Psychoanalysis; Jungian; Adlerian; Attachment Theory; Brief Psychodynamic Therapy.</td>
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<td>Criticisms</td>
<td>Limited supporting research; theories can be convoluted and confusing; lots of disagreement within this camp about theories. Focused more on past than present.</td>
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<td>Techniques/Tools</td>
<td>Free association; dream analysis; analysis of transference; making unconscious conscious; improving ego functioning; explore relationships; interpretation tye current problems to past causes; tie past to present.</td>
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Andrew Nocita, Ph.D. 2014
Steps to developing a case formulation
Based on: Mumma (1998), Persons (1989), and Tompkins (1999)

1. **Develop a comprehensive problem list:** To include both stated problems by the client as well as those assessed by the psychologist. Would include any difficulties related to: generalized levels of distress, sense of well being, specific signs and symptoms of psychopathology, risk of harm to self/others, physical health issues, family/interpersonal issues, work/school issues, and goals stated by collaterals.

2. **Determine the nature of each problem:** What is the origin of the problem? What are the current precipitants of the problem? What are the consequences of the problem?

3. **Identify patterns among the problems:** What are the connections and themes among the problems?

4. **Develop a working hypothesis to explain the problems:** The clinician brings together all the information obtained about the patient in an attempt to develop an organized, comprehensive picture and explanation of the patient’s problems. What is the most parsimonious of all hypotheses generated?

5. **Validate and refine the hypothesis:** The therapist must test out the hypothesis before final acceptance of case formulation and subsequent development of a treatment plan. How do you know if the refined hypothesis has high degree of accuracy? A) The hypothesis accounts for all identified problems B) The antecedents and triggers are easily understood in light of the hypothesis C) Hypothesis based predictions are accurate D) The patient agrees with the hypothesis. E) Treatment based on the hypothesis is successful.

6. **Test and revise the hypothesis during treatment:** Represents a form of continuous quality improvement (CQI) during the treatment. Case formulations are never cast in stone.


Case Presentation
Sample Outline

I. Demographic Information
   a. First name
   b. Age, Sex, Race, Ethnicity
   c. Religion
   d. Family status / Significant relationships
   e. Educational status
   f. Employment status
   g. Family of Origin
   h. Living arrangement
   i. Financial status

II. Presenting Issue
    a. Method of referral
    b. Reason for referral

III. Mental Status Examination
     a. Appearance
     b. Behavior and mannerisms
     c. Attitude
     d. Mood and affect
     e. Speech
     f. Perceptual disturbances
     g. Thought
     h. Sensorium and cognition
     i. Impulse control
     j. Judgment and insight

IV. Historical Information
    a. Childhood / Developmental issues
    b. Social history
    c. Medical history
    d. Mental health history

V. Clinical Impressions
   a. Current symptoms
   b. Symptom history
   c. Severity of symptoms
   d. Strengths
   e. Weaknesses

VI. Supporting Information
    a. Assessment results
    b. Previous psychological reports

VII. Diagnostic Impressions
     a. Axis I
     b. Axis II
     c. Axis III
     d. Axis IV
     e. Axis V

VIII. Case Conceptualization
      a. Summary of case
      b. Origin of disorder(s)
      c. Progression of disorder(s)
      d. Theoretical conceptualization of disorder(s)

IX. Research and Theoretical Opinions
    a. Supporting research
    b. Theoretical opinions
    c. Case examples

X. Recommendations
   a. Treatment goals
   b. Treatment mode
   c. Treatment protocol
   d. Assessment recommendations
   e. Referrals
   f. Treatment conceptualization
   g. Outcome measures
Case Scenario 1: FALSE RUMORS

Bob, age 21, comes to the psychologist’s office, accompanied by his parents, on the advice of his college counselor. He begins the interview by announcing that he has no problems. His parents are always overly concerned about him, and it is only to get them “off my back” that he has agreed to the evaluation. "I am dependent on them financially, but not emotionally."

The psychologist is able to obtain the following story from Bob and his parents. Bob had apparently spread malicious and false rumors about several of the teachers who had given him poor grades, implying that they were having homosexual affairs with students. This, as well as increasingly erratic attendance at his classes over the past term, following the loss of a girlfriend, prompted the school counselor to suggest to Bob and his parents that help was urgently needed. Bob claimed that his academic problems were exaggerated, his success in theatrical productions was being overlooked, and he was in full control of the situation. He did not deny that he spread the false rumors, but he showed no remorse or apprehension about possible repercussions for himself.

Bob is a tall, stylishly dressed young man with a dramatic wave in his hair. His manner is distant, but charming, and he obviously enjoys talking about a variety of intellectual subjects or current affairs. However, he assumes a condescending, cynical, and bemused manner toward the psychologist and the evaluation process. He conveys a sense of superiority and control over the evaluation.

Accounts of Bob’s development are complicated by his bland dismissal of its importance and by the conflicting accounts about it by his parents. His mother was an extremely anxious, immaculately dressed, outspoken woman. She described Bob as having been a beautiful, joyful baby, who was gifted and brilliant. She recalled that after a miscarriage, when Bob was age 1, she and her husband had become even more devoted to his care, giving him “the love for two.” The father was a rugged-looking, soft-spoken, successful man. He recalled a period in Bob’s early life when they had been very close, and he had even confided in Bob about very personal matters and expressed deep feelings. He also noted that Bob had become progressively more resentful with the births of his two siblings. The father laughingly commented that Bob “would have liked to have been the only child.” He recalled a series of conflicts between Bob and authority figures over rules and noted that Bob had expressed disdain for his peers at school and for his siblings.

In his early school years, Bob seemed to play and interact less with other children than most others do. In fifth grade, after a change in teachers, he became arrogant and withdrawn and refused to participate in class. Nevertheless, he maintained excellent grades. In high school he had been involved in an episode similar to the one that led to the current evaluation. At that time he had spread false rumors about a classmate whom he was competing against for a role in the school play.

In general, it became clear that Bob had never been “one of the boys.” He liked dramatics and movies, but had never shown an interest in athletics. He always appeared to be a loner, though he did not complain of loneliness. When asked, he professed to take pride in “being different” from his peers. He also distanced himself from his parents and often responded with silence to their overtures for more communication. His parents felt that behind his guarded demeanor was a sad, alienated, lonely young man. Though he was well known to classmates, the relationships he had with them were generally under circumstances in which he was looked up to for his intellectual or dramatic talents.

Bob conceded that others viewed him as cold or insensitive. He readily acknowledged these qualities, and that he had no close friends, but he dismissed this as unimportant. This represented strength to him. He went on to note that when others complained about these qualities in him, it was largely because of their own weakness. In his view, they envied him and longed to have him care about them. He believed they sought to gain by having an association with him.

Bob had occasional dates, but no steady girlfriends. Although the exact history remains unclear, he acknowledged that the girl whose loss seemed to have led to his escalating school problems had been someone whom he cared about. She was the first person with whom he had had a sexual relationship. The relationship had apparently dissolved after she had expressed an increasing desire to spend more time with her girlfriends and to go to school social events.
Case Scenario 2: EATING AND BUYING

Ellen Farber, a single 35-year-old insurance company executive, came to a psychiatric emergency room of a university hospital with complaints of depression and the thought of driving her car off a cliff. An articulate, moderately overweight, sophisticated woman, Ms. Farber appeared to be in considerable distress. She reported a 6-month period of increasingly persistent dysphoria and lack of energy and pleasure. Feeling as if she were "made of lead," Ms. Farber had recently been spending 15-20 hours a day in her bed. She also reported daily episodes of binge eating, when she would consume "anything I can find," including entire chocolate cakes or boxes of cookies. She reported problems with intermittent binge eating since adolescence, but these episodes had recently increased in frequency, resulting in a 20-pound weight gain over the past few months. In the past her weight had often varied greatly as she had gone on and off a variety of diets. She denied preoccupation with thinness or a history of episodes of vomiting or other weight-reduction procedures to compensate for the binge eating.

She attributed her increasing symptoms to financial difficulties. Ms. Farber had been fired from her job 2 weeks before coming to the emergency room. She claimed it was because she "owed a small amount of money." When asked to be more specific, she reported owing $150,000 to her former employers and another $100,000 to various local banks. Further questions revealed that she had always had difficulty managing her money and had been forced to declare bankruptcy at age 27. From age 30 to age 33, she had used her employer's credit cards to finance weekly "buying binges," accumulating the $150,000 debt. She denied past or present symptoms of mania, obsessive thoughts, or a compulsion to buy, but rather reported that spending money alleviated her chronic feelings of loneliness, isolation, and sadness. Experiencing only temporary relief, every few days she would impulsively buy expensive jewelry, watches, or multiple pairs of the same shoes.

Two years ago, when her employers noticed the massive credit card bills, Ms. Farber had nothing she could sell to reduce the debt. Her employers allowed her to pay off the debts by continuing to work for them and giving them part of her salary. However, she could not stop her spending. She financed further purchases by a process she called "check kiting." She would open a checking account at one bank, overdraw from that account to open a second account at another bank, and then overdraw from the second account to open an account at a third bank. Over 2 years this escalating process led to her additional $100,000 debt. When the banks discovered the fraudulent practice 2 weeks ago, they contacted Ms. Farber's employers, who promptly fired her, which led to her current desperate state.

In addition to lifelong feelings of emptiness, Ms. Farber described chronic uncertainty about what she wanted to do in life and with whom she wanted to be friends. She had many brief, intense relationships with both men and women, but her quick temper led to frequent arguments and even physical fights. Although she had always thought of her childhood as happy and carefree, when she became depressed, she began to recall episodes of abuse by her mother. Initially, she said she had dreamt that her mother had pushed her down the stairs when she was only 6, but she then began to report previously unrecognized memories of beatings or verbal assaults by her mother.

Ms. Farber was admitted to the hospital for inpatient management of her depression.
Case Scenario 3: EMPTY SHELL

The patient is a 23-year-old veterinary assistant admitted for her first psychiatric hospitalization. She arrived late at night, referred by a local psychiatrist, saying “I don’t really need to be here.”

Three months before admission, the patient learned that her mother had become pregnant. She began drinking heavily, ostensibly in order to sleep nights. While drinking she became involved in a series of “one-night stands.” Two weeks before admission, she began feeling panicky and began having experiences in which she felt as if she were removed from her body and in a trance. During one of these episodes, she was stopped by the police while wandering on a bridge at night. The next day, in response to hearing a voice repeatedly telling her to jump off a bridge, she ran to her supervisor and asked for help. Her supervisor, seeing her distraught and also noting scars from a recent wrist slashing, referred her to a psychiatrist, who then arranged for her immediate hospitalization.

At the time of the hospitalization, the patient appeared as a disheveled and frail, but appealing waif. She was cooperative, coherent, and frightened. Although she did not feel hospitalization was needed, she welcomed the prospect of relief from her anxiety and depersonalization. She acknowledged that she had had feelings of loneliness and inadequacy and brief periods of depressed mood and anxiety since adolescence. Recently she had been having fantasies that she was stabbing herself or a little baby with a knife. She complained that she was “just an empty shell that is transparent to everyone.”

The patient’s parents divorced when she was three, and for the next five years she lived with her maternal grandmother and her mother, who had a severe drinking problem. The patient had night terrors during which she would frequently end up sleeping with her mother. At six she went to a special boarding school for a year and a half, after which she was withdrawn by her mother, against the advice of the school. When she was eight, her maternal grandmother died; and she recalls trying to conceal her grief about this from her mother. She spent most of the next two years living with various relatives, including a period with her father, whom she had not seen since the divorce. When she was nine, her mother was hospitalized with a diagnosis of schizophrenia. From age 10 through college, the patient lived with an aunt and uncle but had ongoing and frequent contacts with her mother. Her school record was consistently good.

Since adolescence she has dated regularly, having an active, but rarely pleasurable, sex life. Her relationships with men usually end abruptly after she becomes angry with them when they disappoint her in some apparently minor way. She then concludes that they were “no good to begin with.” She has had several roommates, but has had trouble establishing a stable living situation because of her jealousy about sharing her roommates with others and her manipulative efforts to keep them from seeing other people.

Since college, she has worked steadily and well as a veterinary assistant. At the time of admission, she was working a night shift in a veterinary hospital and living alone.
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<th>Diagnosis</th>
<th>Symptoms</th>
<th>Differentials/Associations</th>
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<td>The Lonely Housewife</td>
<td>Major Depressive Disorder</td>
<td>The following symptoms are associated with depression:</td>
<td>Dysthmic Disorder</td>
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<td>The Burnt-out Manager</td>
<td></td>
<td>- Depressed mood (such as feelings of sadness or emptiness)</td>
<td>Bipolar Disorder</td>
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<td>The Long-time Widow</td>
<td></td>
<td>- Reduced interest in activities that used to be enjoyed, sleep disturbances (either not being able to sleep well or sleeping to much)</td>
<td>Adjustment Disorder</td>
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<td>Drowning His Sorrows</td>
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<td>- Loss of energy or a significant reduction in energy level</td>
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<td></td>
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<td>- Difficulty concentrating, holding a conversation, paying attention, or making decisions that used to be made fairly easily</td>
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<td>- Suicidal thoughts or intentions.</td>
<td></td>
</tr>
<tr>
<td>Mission to Mars</td>
<td>Schizophrenia</td>
<td>Symptoms of Schizophrenia typically begin between adolescence and early adulthood for males and a few years later for females, and usually as a result of a stressful period (such as beginning college or starting a first full time job). Initial symptoms may include:</td>
<td>Schizoaffective Disorder</td>
</tr>
<tr>
<td>Paranoia</td>
<td></td>
<td>- Delusions and hallucinations</td>
<td>Substance Intoxication</td>
</tr>
<tr>
<td>Religious Preoccupation</td>
<td></td>
<td>- Disorganized behavior and/or speech</td>
<td>Delusional Disorder</td>
</tr>
<tr>
<td>The Mad Artist</td>
<td>Bipolar Disorder</td>
<td>For a diagnosis of Bipolar I disorder, a person must have at least one manic episode.</td>
<td>Major Depression</td>
</tr>
<tr>
<td>Late-Night Shopper</td>
<td></td>
<td>- Mania is sometimes referred to as the other extreme to depression. Mania is an intense high where the person feels euphoric, almost indestructible in areas such as personal finances, business dealings, or relationships. They may have an elevated self-esteem, be more talkative than usual, have flight of ideas, a reduced need for sleep, and be easily distracted. The high, although it may sound appealing, will often lead to severe difficulties in these areas, such as spending much more money than intended, making extremely rash business and personal decisions, involvement in dangerous sexual behavior, and/or the use of drugs or alcohol.</td>
<td>Schizophrenia</td>
</tr>
<tr>
<td>The Inventor</td>
<td></td>
<td>- Depression is often experienced as the high quickly fades and as the consequences of their activities becomes apparent, the depressive episode can be exacerbated.</td>
<td>Schizoaffective Disorder</td>
</tr>
<tr>
<td>The Stoic Man</td>
<td>Dysthmic</td>
<td>Depressed mood for most of the day, for more days than not, and</td>
<td>Major Depression</td>
</tr>
</tbody>
</table>
| Forcing a Smile | Disorder | ongoing for at least two years. During this time, there must be two or more of the following symptoms:  
- Under— or over eating  
- Sleep difficulties  
- Fatigue  
- Low self-esteem  
- Difficulty with concentration or decision making,  
- Feelings of hopelessness  
- There can also not be a diagnosis of Major Depression for the first two years of the disorder, and has never been a manic or hypo-manic episode. | Adjustment Disorder | Bipolar Disorder |
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Disfigured Beauty Contestant 200 Pound Weakling</td>
<td>Body Dysmorphic Disorder</td>
<td>Preoccupation with a specific body part and the belief that this body part is deformed or defective. The preoccupation is significantly excessive and causes distress or significant impairment in functioning. It is not better explained by another disorder such as dissatisfaction with body shape in anorexia or delusions associated with a psychotic disorder.</td>
<td>Hypochondriasis</td>
<td>---</td>
</tr>
<tr>
<td>Mr. Clean The Perfectionist</td>
<td>Obsessive Compulsive Disorder</td>
<td>The key features of this disorder include obsessions (persistent, often irrational, and seemingly uncontrollable thoughts) and compulsions (actions which are used to neutralize the obsessions). A good example of this would be an individual who has thoughts that he is dirty, infected, or otherwise unclean which are persistent and uncontrollable. In order to feel better, he washes his hands numerous times throughout the day, gaining temporary relief from the thoughts each time. For these behaviors to constitute OCD, it must be disruptive to everyday functioning (such as compulsive checking before leaving the house making you extremely late for all or most appointments, washing to the point of excessive irritation of your skin, or inability to perform everyday functions like work or school because of the obsessions or compulsions).</td>
<td>Schizophrenia</td>
<td>---</td>
</tr>
<tr>
<td>Gulf-War Veteran 9/11 Survivor</td>
<td>Post-traumatic Stress Disorder</td>
<td>Symptoms include re-experiencing the trauma through nightmares, obsessive thoughts, and flashbacks (feeling as if you are actually in the traumatic situation again). There is an avoidance component as well, where the individual avoids situations, people, and/or objects that remind him or her about the traumatic event (e.g., a person experiencing PTSD after a serious car accident might avoid driving or being a passenger in a car). Finally, there is increased anxiety in general, possibly with a heightened startle response (e.g., very jumpy, startle easy by noises).</td>
<td>Schizophrenia</td>
<td>Major Depression Panic Disorder</td>
</tr>
<tr>
<td>The Binge Drinker Happy Hour Socialite The DUI Collector</td>
<td>Alcohol Dependence</td>
<td>Substance use history that includes the following: (1) substance abuse; (2) continuation of use despite related problems; (3) increase in tolerance (more of the drug is needed to achieve the same effect); and (4)</td>
<td>Alcohol Abuse</td>
<td>Major Depression</td>
</tr>
<tr>
<td>Title</td>
<td>Disorder/Disorder</td>
<td>Description</td>
<td>Disorder/Disorder</td>
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<td>----------------------------------------------------------------------</td>
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<tr>
<td>Drowning His Sorrows</td>
<td></td>
<td>withdrawal symptoms.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Dysfunctional Family</td>
<td>Anorexia Nervosa</td>
<td>Most often diagnosed in females (up to 90%). Anorexia is characterized by failure to maintain body weight of at least 85% of what is expected, fear of losing control over your weight of or becoming ‘fat.’ There is typically a distorted body image, where the individual sees him- or herself as overweight despite overwhelming evidence to the contrary.</td>
<td>Major Depression</td>
<td>Body Dysmorphic Disorder</td>
</tr>
<tr>
<td>The Future Model</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>The Road Rage</td>
<td>Intermittent Explosive Disorder</td>
<td>This disorder is characterized by frequent and often unpredictable episodes of extreme anger or physical outbursts. Between episodes, there is typically no evidence of violence or physical threat.</td>
<td>Major Depression</td>
<td></td>
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<tr>
<td>The Mean Drunk</td>
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<td></td>
</tr>
<tr>
<td>The Earring Fetish</td>
<td>Kleptomania</td>
<td>Kleptomania involves the failure to resist impulses to steal things that are not needed for either personal use or for their monetary value. There is typically anxiety prior to the act of theft and relief or gratification afterward. If the theft is related to vengeance or psychosis, kleptomania should not be diagnosed. (Kleptomania is quite rare, where common shoplifting is not)</td>
<td>Antisocial Personality Disorder</td>
<td></td>
</tr>
<tr>
<td>The Grocery Store Bandit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Online Addict</td>
<td>Pathological Gambling</td>
<td>Persistent and maladaptive pattern of gambling that causes difficulties with interpersonal, financial, and vocational functioning.</td>
<td>Major Depression</td>
<td></td>
</tr>
<tr>
<td>Poker with the Guys</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>The Doctor Shopper</td>
<td>Hypochondriasis</td>
<td>Preoccupation with fears of having a serious disease based upon a misinterpretation of bodily sensations. The preoccupation exists despite assurance from a physician that the individual does not have a serious disease.</td>
<td>Major Depression</td>
<td>Body Dysmorphic Disorder</td>
</tr>
<tr>
<td>What if it's HIV</td>
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<tr>
<td>Exercise Fanatic</td>
<td>Bulimia Nervosa</td>
<td>The key characteristics of this disorder include bingeing (the intake of large quantities of food) and purging (elimination of the food through artificial means such as forced vomiting, excessive use of laxatives, periods of fasting, or excessive exercise).</td>
<td>Anorexia Nervosa</td>
<td>Major Depression</td>
</tr>
<tr>
<td>Uncontrollable Gag Reflex</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Common Criminal</td>
<td>Antisocial Personality Disorder</td>
<td>The symptoms of antisocial personality disorder include a longstanding pattern (after the age of 15) of disregard for the rights of others. There is a failure to conform to society’s norms and expectations that often results in numerous arrests or legal involvement as well as a history of deceitfulness where the individual attempts to con people or use trickery for personal profit. Impulsiveness is often present, including angry outbursts, failure to consider consequences of behaviors, irritability, and/or physical assaults. Some argue that a major component of this disorder is the reduced ability to feel empathy for other people. This inability to see the hurts, concerns, and other feelings of people often results in a disregard for these aspects of human interaction. Finally, irresponsible behavior often accompanies</td>
<td>Major Depression</td>
<td>Intermittent Explosive Disorder</td>
</tr>
<tr>
<td>The Con Artist</td>
<td></td>
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</tr>
</tbody>
</table>
this disorder as well as a lack of remorse for wrongdoings.

<table>
<thead>
<tr>
<th>The Cutter</th>
<th>Borderline Personality Disorder</th>
<th>Major Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>I Love You/I Hate You</td>
<td>The major symptoms of this disorder revolve around unstable relationships, poor or negative sense of self, inconsistent moods, and significant impulsivity. There is an intense fear of abandonment with this disorder that interferes with many aspects of the individual's life. This fear often acts as a self-fulfilling prophecy as they cling to others, are very needy, feel helpless, and become overly involved and immediately attached. When the fear of abandonment becomes overwhelming, they will often push others out of their life as if trying to avoid getting rejected. The cycle most often continues, as the individual will then try everything to get people back in his or her life and once again becomes clingy, needy, and helpless. The fact that people often do leave someone who exhibits this behavior only proves to support their distorted belief that they are insignificant, worthless, and unloved. At this point in the cycle, the individual may exhibit self-harming behaviors such as suicide attempts, mock suicidal attempts (where the goal is to get rescued and lure others back into the individual's life), cutting or other self-mutilating behavior. There is often intense and sudden anger involved, directed both at self and others, as well a difficulty controlling destructive behaviors.</td>
<td></td>
</tr>
<tr>
<td>The Beauty Queen</td>
<td>Narcissistic Personality Disorder</td>
<td>Antisocial Personality Disorder</td>
</tr>
<tr>
<td>World’s Most Handsome Man</td>
<td>The symptoms of narcissistic personality disorder revolve around a pattern of grandiosity, need for admiration, and sense of entitlement. Often individuals feel overly important and will exaggerate achievements and will accept, and often demand, praise and admiration despite worthy achievements. They may be overwhelmed with fantasies involving unlimited success, power, love, or beauty and feel that they can only be understood by others who are, like them, superior in some aspect of life. There is a sense of entitlement, of being more deserving than others based solely on their superiority. These symptoms, however, are a result of an underlying sense of inferiority and are often seen as overcompensation. Because of this, they are often envious and even angry of others who have more, receive more respect or attention, or otherwise steal away the spotlight.</td>
<td></td>
</tr>
<tr>
<td>The Stalker</td>
<td></td>
<td>Major Depression</td>
</tr>
</tbody>
</table>
USER’S GUIDE FOR THE

SCID-I

STRUCTURED CLINICAL INTERVIEW FOR DSM-IV-TR AXIS I DISORDERS

(RESEARCH VERSION)

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Several drafts of the DSM-IV SCID were made available to a group of experienced SCIDers, who provided extremely helpful suggestions. We are especially grateful to: Laurie Arnold, Melanie M. Biggs, Nancee Blum, Dona Davies, Dorothy Dewart, David Dunnam, Lynn Gladis, Gretchen L. Haas, James D. Herbert, Janet Lavelle, Stephanie Lewis, Kathy Shores-Wilson, Diane Stegman, Suzanne Sunday, Joseph Ventura, and Jan Weissenburger.

Nina Rosenthal provided invaluable assistance in the production of the SCID for DSM-IV.

The SCID questions for Somatization Disorder were adapted from the Diagnostic Interview Schedule, developed by Lee Robins and John Helzer at Washington University Department of Psychiatry, St. Louis, Missouri. We also gratefully acknowledge the help of Katherine Phillips in the development of the SCID questions for Body Dysmorphic Disorder.

The authors give special thanks to Shoshana Peyser for her meticulously careful reading of the SCID for DSM-IV-TR.
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1. INTRODUCTION

The Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I) is a semistructured interview for making the major DSM-IV Axis I diagnoses. It is administered by a clinician or trained mental health professional who is familiar with the DSM-IV classification and diagnostic criteria (APA, 1994). The subjects may be either psychiatric or general medical patients, or individuals who do not identify themselves as patients, such as subjects in a community survey of mental illness or family members of psychiatric patients. The language and diagnostic coverage make the SCID most appropriate for use with adults (age 18 or over), but with slight modification, it may be used with adolescents. Anyone with an 8th grade education should be able to understand the language of the SCID. Some individuals with severe cognitive impairment, agitation, or severe psychotic symptoms cannot be interviewed using the SCID. This should be evident in the first ten minutes of the Overview and in such a case there is no point in torturing the subject (or yourself) by continuing the SCID interview. The SCID may be used instead as a diagnostic checklist, with information obtained from other sources (see page 12).

The SCID-II is for evaluating the DSM-IV Axis II Personality Disorders. Ten of them appear in the Personality Disorders section of DSM-IV; two of them (Negativistic Personality Disorder and Depressive Personality Disorder) appear in Appendix B (Criteria Sets and Axes Provided For Further Study). The SCID-II is published as a separate instrument with a separate instruction manual. (First, et. al., 1997).

2. HISTORY OF THE SCID

The publication of DSM-III in 1980 revolutionized psychiatry with its inclusion of specified diagnostic criteria for virtually all of the mental disorders (APA, 1980). Prior to 1980 there were several sets of diagnostic criteria, such as the Feighner Criteria (Feighner, et. al., 1972) and the Research Diagnostic Criteria (RDC) (Spitzer, et. al., 1978), as well as structured interviews designed to make diagnoses according to these systems. In 1983, in anticipation of the widespread adoption of the DSM-III criteria as the standard language for describing research subjects, work started on the SCID as an instrument for making DSM-III diagnoses. The SCID incorporated several features not present in previous instruments that would facilitate its use in psychiatric research, such as the inclusion of an Overview section that allows the patient to describe the development of the current episode of illness, and a modular design enabling researchers to eliminate consideration of major diagnostic classes that are irrelevant to their studies.

In 1983 the National Institute of Mental Health, also recognizing the need for a clinical diagnostic assessment procedure for making DSM-III diagnoses, issued a Request for a Proposal to develop such a procedure.
Based on pilot work with the SCID, a contract was awarded to further develop the instrument. In April 1985, the Biometrics Research Department received a two-year grant to field test the SCID and to determine its reliability in several different clinical and nonclinical subject groups (Spitzer, et al., 1993; Williams, et al., 1993). The SCID for DSM-III-R was published by American Psychiatric Press, Inc. in May 1990. Work on the DSM-IV revision of the SCID began in fall 1993. Draft versions of the revision were field tested by interested researchers during the second half of 1994. A final version of the SCID for DSM-IV was produced in February 1996. Several revisions of the SCID have been made since February 1996. The most extensive was made in February 2001 revision when the SCID was updated for the DSM-IV text revision (DSM-IV-TR). Refer to the SCID web site (www.scid4.org) for a list of the specific changes made as a consequence of each of the SCID revisions.

3. VERSIONS OF THE SCID

The SCID was originally designed to meet the needs of both researchers and clinicians. This involved making the SCID detailed enough for the research community, but still user-friendly enough for clinicians. This duality of purpose ultimately created problems for researchers because a lot of potentially useful diagnostic information (e.g. subtypes) was left out of the DSM-III-R version of the SCID in order to keep it from becoming too cumbersome. However, many clinicians felt that the amount of detail that was included in the SCID still rendered it too long and complex. We have (hopefully) solved this problem by splitting the SCID for DSM-IV into two versions: Clinician and Research.

3.1 SCID Research Version

The research version of the SCID is described in this User’s Guide. It is much longer than the Clinician Version because it contains more disorders, subtypes, severity and course specifiers, and provisions for coding the specific details of past mood episodes. It is designed to include most of the information that is diagnostically useful to researchers. It is expected that researchers will customize this version of the SCID to fit their needs, choosing only those parts that are relevant to their particular studies. For this reason, the SCID-I is published in a loose page format. Users of the SCID are also encouraged to modify the instrument to accommodate the requirements of a particular study--for example, by adding additional items such as rating scales of severity. This may require updating the GO TO statements as well. (Refer to Appendix A for advice about modifying the SCID for a particular research study.)

There are three ways in which research investigators typically use the SCID. Most often the SCID is used to select a study population. For example, in a study of the effectiveness of several treatments for depression, the
SCID can be used to insure that all of the study subjects have symptoms that meet the DSM-IV criteria for Major Depressive Disorder. The SCID is also used to exclude subjects with certain disorders. For example, in the study mentioned above, the researchers may wish to use the SCID to exclude all patients with a history of any Substance Use Disorder. Finally, the SCID is often used to characterize a study population in terms of current and past psychiatric diagnoses.

3.2 Clinician Version of the SCID (SCID-CV)

This shortened version of the SCID is published by the American Psychiatric Press, Inc., and is designed for use in clinical settings as a way of insuring standardized assessments. It includes full diagnostic evaluations of only those DSM-IV diagnoses most commonly seen in clinical practice and excludes most of the subtypes and specifiers included in the Research Version. Furthermore, it has been reformatted into two documents: a reusable administration booklet and a separate (one time use) score sheet booklet in which the interviewer makes all of the notes and ratings.

The Clinician Version of the SCID can be used in at least three ways. In the first, a clinician does his or her usual interview and then uses a portion of the SCID-CV to confirm and document a suspected DSM-IV diagnosis. For example, the clinician, hearing the patient describe what appear to be panic attacks, may use the Anxiety Disorder module of the SCID-CV to inquire about the specific DSM-IV criteria for Panic Disorder. In this instance, the SCID-CV provides the clinician not only with the actual DSM-IV criteria for Panic Disorder, but also with the SCID questions which are efficient ways of obtaining the information necessary to judge the diagnostic criteria. In the second, the complete SCID-CV and SCID-II (for Personality Disorders) are administered as an intake procedure, insuring that all of the major Axis I and Axis II diagnoses are systematically evaluated. The SCID has been used in this way in hospitals and clinics by mental health professionals of varying backgrounds, including psychiatry, psychology, psychiatric social work, and psychiatric nursing. Finally, the SCID-CV can be helpful in improving the interview skills of students in the mental health professions. The SCID-CV can provide them with a repertoire of useful questions to elicit information from a patient that will be the basis for making judgments about the diagnostic criteria. Through repeated administrations of the SCID-CV, students become familiar with the DSM-IV criteria and at the same time incorporate useful questions into their interviewing repertoire.
4. SCID EDITIONS OF RESEARCH VERSION
(SCID-P, SCID-P/PSY SCREEN, SCID-NP)

Two standard editions of the research version of the SCID are available for diagnosing the major Axis I and II disorders.

The **SCID-I/P (Patient Edition)** is designed for use with subjects who are identified as psychiatric patients. It contains the following modules:

SCID-I/P Summary Score Sheet
SCID-I/P Overview
A. Mood Episodes
B. Psychotic and Associated Symptoms
C. Psychotic Disorders
D. Mood Disorders
E. Substance Use Disorders
F. Anxiety Disorders
G. Somatoform Disorders
H. Eating Disorders
I. Adjustment Disorder
J. Optional Module

For settings in which psychotic disorders are expected to be rare (e.g., an outpatient anxiety clinic) or for studies in which patients with psychotic disorders are being screened out, an abridged edition of the **SCID-I/P (SCID-I/P W/ PSYCHOTIC SCREEN)** is available. This edition replaces the B and C modules with a combined B/C module that includes only screening questions about psychotic symptoms, omitting the lengthy psychotic disorders decision tree so that a specific psychotic disorder diagnosis is not made. In addition, the **SCID-I/P (W/PSYCHOTIC SCREEN)** has an abridged summary score sheet that does not include psychotic disorders.

The **SCID-I/NP (Non-patient Edition)** is for use in studies in which the subjects are not identified as psychiatric patients (e.g., community surveys, family studies, research in primary care). The diagnostic modules of the SCID-I/NP are the same as those of the SCID-I/P (W/PSYCHOTIC SCREEN); the only difference in the two versions is in the Overview section. In the SCID-I/NP there is no assumption of a chief complaint, and other questions are used to inquire about a history of psychopathology.

The SCID-I/NP contains the following modules:

SCID-I/NP Summary Score Sheet
SCID-I/NP Overview
A. Mood Episodes
B/C. Psychotic Screening
D. Mood Disorders
E. Substance Use Disorders
F. Anxiety Disorders
G. Somatoform Disorders
H. Eating Disorders
I. Adjustment Disorder
J. Optional Module

It is possible to convert a SCID-I/P into a SCID-I/NP by substituting the appropriate Summary Score Sheet, Overview and Psychotic Screening Module.

5. DIAGNOSTIC COVERAGE

The table below indicates the symptoms, episodes, and disorders that are included in the SCID modules.

<table>
<thead>
<tr>
<th>Table 1: DIAGNOSTIC COVERAGE OF SCID MODULES</th>
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<tbody>
<tr>
<td><strong>Module A: Mood Episodes</strong></td>
</tr>
<tr>
<td>Major Depressive Episode (current/past)</td>
</tr>
<tr>
<td>Manic Episode (current/past)</td>
</tr>
<tr>
<td>Hypomanic Episode (current/past)</td>
</tr>
<tr>
<td>Dysthymic Disorder (current only)</td>
</tr>
<tr>
<td>Mood Disorder Due to a General Medical</td>
</tr>
<tr>
<td>Condition</td>
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<tr>
<td>Substance-Induced Mood Disorder</td>
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<tr>
<td><strong>Module B: Psychotic Symptoms</strong></td>
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<tr>
<td>Delusions</td>
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<tr>
<td>Hallucinations</td>
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<tr>
<td>Disorganized Speech and Behavior</td>
</tr>
<tr>
<td>Catatonic Behavior</td>
</tr>
<tr>
<td>Negative Symptoms</td>
</tr>
<tr>
<td><strong>Module C: Psychotic Disorders</strong></td>
</tr>
<tr>
<td>Schizophrenia</td>
</tr>
<tr>
<td>Paranoid Type</td>
</tr>
<tr>
<td>Catatonic Type</td>
</tr>
<tr>
<td>Disorganized Type</td>
</tr>
<tr>
<td>Undifferentiated Type</td>
</tr>
<tr>
<td>Residual Type</td>
</tr>
<tr>
<td>Schizophreniform Disorder</td>
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<tr>
<td>Schizoaffective Disorder</td>
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<tr>
<td>Delusional Disorder</td>
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<tr>
<td>Brief Psychotic Disorder</td>
</tr>
<tr>
<td>Psychotic Disorder Due to a General Medical</td>
</tr>
<tr>
<td>Condition</td>
</tr>
<tr>
<td>Substance-Induced Psychotic Disorder</td>
</tr>
<tr>
<td>Psychotic Disorder Not Otherwise Specified</td>
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</tbody>
</table>
| Module D: *Mood Disorders* | Bipolar I Disorder  
Bipolar II Disorder  
Other Bipolar Disorders (Cyclothymic Disorder, Bipolar Disorder NOS)  
Major Depressive Disorder  
Depressive Disorder Not Otherwise Specified |
|----------------------------|-------------------------------------------------|
| Module E: *Substance Use Disorders* | Alcohol Dependence  
Alcohol Abuse  
Amphetamine Dependence  
Amphetamine Abuse  
Cannabis Dependence  
Cannabis Abuse  
Cocaine Dependence  
Cocaine Abuse  
Hallucinogen Dependence  
Hallucinogen Abuse  
Opioid Dependence  
Opioid Abuse  
Phencyclidine Dependence  
Phencyclidine Abuse  
Sedative/Hypnotic/Anxiolytic Dependence  
Sedative/Hypnotic/Anxiolytic Abuse  
Polysubstance Dependence  
Other or Unknown Substance Dependence  
Other or Unknown Substance Abuse |
| Module F: *Anxiety Disorders* | Panic Disorder With Agoraphobia  
Panic Disorder Without Agoraphobia  
Agoraphobia Without History of Panic Disorder  
Social Phobia  
Specific Phobia  
Obsessive-Compulsive Disorder  
Posttraumatic Stress Disorder  
Generalized Anxiety Disorder (current only)  
Anxiety Disorder Due to a General Medical Condition  
Substance-Induced Anxiety Disorder  
Anxiety Disorder Not Otherwise Specified |
| Module G: "Somatoform Disorders" | Somatization Disorder (current only)  
Undifferentiated Somatoform Disorder (current only)  
Pain Disorder (current only)  
Hypochondriasis (current only)  
Body Dysmorphic Disorder (current only) |
| Module H: *Eating Disorders* | Anorexia Nervosa  
Bulimia Nervosa  
Binge Eating Disorder (Appendix category) |
| Module I: *Adjustment Disorder* | Adjustment Disorder (current only) |
6. BASIC FEATURES OF THE SCID

Inclusion of an Overview. Before systematically inquiring about the presence or absence of particular DSM-IV criterion items, the SCID begins with an open-ended Overview of the present illness and past episodes of psychopathology. This Overview provides an opportunity for the subject to describe the presenting problem in his or her own words, as well as collecting certain types of information that may not be covered in the course of assessing specific diagnostic criteria (e.g., prior treatment, social and occupational functioning, context of the development of the psychopathology). By the end of the Overview, the interviewer should have gathered enough information to formulate a tentative differential diagnosis.

Diagnostic Flow. The sequence of questions in the SCID is designed to approximate the differential diagnostic process of an experienced clinician. Since the DSM-IV diagnostic criteria are embedded in the SCID and are assessed as the interview progresses, the interviewer is, in effect, continually testing diagnostic hypotheses. Note that for some disorders, the diagnostic criteria are not listed in the same order as in DSM-IV, but have been reordered to make the SCID interview more efficient or user-friendly. For example, the D criterion for Schizophrenia is listed right after the A criterion to allow the interviewer to skip out of Schizophrenia immediately if the temporal relationship between psychotic and mood symptoms is not consistent with a diagnosis of Schizophrenia.

Ratings are of Criterion Items, NOT of answers to questions. Although specific structured questions are provided to help elicit diagnostic information, it is important to keep in mind the fact that the ratings on the SCID are of the diagnostic criteria, and not necessarily the answers to the questions. Although the majority of the SCID questions can be answered by a simple YES or NO, more often than not an unelaborated YES answer is not enough information to determine whether a criterion is met. It is usually necessary to ask the subject to elaborate or provide specific examples. For instance, one of the questions for a Major Depressive Episode asks whether the subject has had “trouble thinking or concentrating.” Before rating the corresponding criterion (i.e., “diminished ability to think or concentrate...”) as present, the interviewer should ask additional questions (i.e., “what kinds of things do you have trouble concentrating on?”). A positive rating should be made only after the interviewer is satisfied that the
criterion is met. Sometimes this might entail seeking corroborating information from other sources (i.e., family members, previous records). In some cases it may be useful to read or paraphrase the wording of the criterion in order to make the concept clearer to a subject.

Ultimately, the interviewer must make a clinical judgment as to whether a diagnostic criterion is met. If the interviewer is convinced that a particular symptom is present, he or she should not allow a subject's denial of the symptom to go unchallenged. In rare cases an item may be coded as present even when the subject steadfastly denies it--e.g., a subject who claims that spending two hours a day in a hand washing ritual is not "excessive or unreasonable." On the other hand, if an interviewer doubts that a symptom is present even after hearing the subject describe it, the item should be rated as not present. It is not necessary to get the subject to agree that the symptom is not present.

Time Frame of Diagnoses. With a few exceptions, the SCID determines whether an Axis I diagnosis has ever been present (lifetime prevalence) and whether or not there is a current episode (defined as meeting diagnostic criteria within the past month). The exceptions are the following disorders, for which only current episodes are considered in the SCID: Dysthymic Disorder, Generalized Anxiety Disorder, all Somatoform Disorders, and Adjustment Disorder. The SCID recommends using one month as the time period for defining "current"--i.e., a disorder is considered to be current if the full criteria have been met at any time during the current month. Although this time frame makes sense in most situations, some investigators may want to define a current episode with a different time period.

Summary Score Sheet. When the interview is completed, the clinician records diagnoses on a Summary Score Sheet. The Score Sheet includes: 1) ratings indicating whether each Axis I disorder covered by the SCID has ever been present during the subject’s lifetime (or present only at a subthreshold level) and whether criteria for the disorder are currently met; 2) ratings for the presence of certain specifiers and subtypes; 3) an indication of the "principal diagnosis"; 4) the DSM-IV Psychosocial and Environmental Problems Checklist (Axis IV); and the Global Assessment of Functioning Scale (Axis V) which enables the clinician to record the subject's poorest level of functioning during the past month, independent of diagnosis.

Sources of Information. The interviewer should use all sources of information available about the subject in making the ratings. This might include referral notes and the observations of family members and friends. In some cases the interviewer may need to confront a subject with discrepancies between his or her account and other sources of information.

When the subject is a poor historian (e.g., a hospitalized patient with acute psychotic symptoms and agitation, a chronic patient with cognitive impairment), much of the information may by necessity be drawn from the
medical records. Before beginning to interview such a patient, the interviewer should review the chart, note symptoms and dates of prior hospitalizations in the Life Chart, and record a brief description of the pertinent symptoms in the section of the SCID in which they are assessed (e.g., record psychotic symptoms in the B module). In such cases, interviewing the patient may provide relatively little additional information, and the SCID is not so much an interview guide as a place to systematically record symptoms that have been documented in the hospital records.

7. ADMINISTRATION

Ordinarily, the Axis I SCID is administered in a single sitting and takes from 60 to 90 minutes, depending on the complexity of the psychiatric history and the ability of the subject to describe his or her psychopathology succinctly. Usually the SCID II is administered following the Axis I SCID, sometimes on another day. (Instructions for administering the SCID II are contained in the SCID-II User's Guide, published separately.) In some instances and with certain types of patients, the SCID may have to be administered over several sittings. If additional information about past psychopathology becomes available after the interview is completed, the SCID should be modified accordingly.

8. SCID CONVENTIONS AND USAGE

Note: When you review the next section, we recommend that you have a copy of the SCID to refer to.

1. Three column format: The left-hand side of each page of the SCID consists of the interview questions and directions (in capital letters) to the interviewer. In addition, the left-hand column contains location markers (used to show target locations for skip-outs), indicated by phrases in bold and surrounded by asterisks (for example, "SCHIZOPHRENIA"). The diagnostic criteria to which the interview questions refer are in the middle column of the page. The right-hand column of each page contains the codes for rating the criteria. To the far right, in a small font, are the optional data field indicators. They are provided as a convenience for those situations in which the SCID data is being entered into a computerized data base. By adopting these data field indicators as variable names in the computer program, the researcher can more easily compare his or her SCID data with other SCID data bases that have set up using this naming convention for the data fields.

2. Lifetime history: The initial question for each diagnosis generally begins with "Have you ever had...?" to prepare the subject for inquiry about a lifetime history
of the disorder. (The A Module is an exception in that current and past Major Depressive, Manic, and Hypomanic Episodes are inquired about separately.)

3. Questions asked verbatim: Questions not in parentheses are to be asked verbatim of every subject. The only exception to this basic SCID rule is in those instances in which the subject has already provided the necessary information earlier in the SCID interview. For example, if during the Overview the subject states that the reason for coming to the clinic is that he or she has been very depressed for the past couple of months, the interviewer would not then ask verbatim the initial question in the A module: “In the past month, has there been a period of time when you were depressed or down for most of the day nearly every day?” In such instances, however, the interviewer should NOT just assume that the symptom is present and code the item “3” without asking for confirmation, because some aspect of the criterion may not have been adequately explored (e.g., duration). Instead, the interviewer should confirm the information already obtained by paraphrasing the original question. For example, the interviewer may say “You’ve already told me that you were feeling depressed for the last couple of months. Was there a two-week period in which you were depressed for most of the day, nearly every day?”

4. Parenthetical questions: Questions in parentheses are to be asked when necessary to clarify responses. This does not imply that the information the question is designed to elicit is any less critical. For instance, the question for the first item in a Major Depressive Episode has the inquiry ”as long as two weeks?” in parentheses. This indicates that if the subject mentions the duration of the depressed mood, it is not necessary to ask if it lasted two weeks. But the two-week duration of the depressed mood is still a critical requirement for rating this symptom as present. In addition, the interviewer is encouraged to add as many of his or her own questions as necessary to feel confident of the validity of the rating.

5. OWN WORDS: Many of the questions contain the phrase OWN WORDS in parentheses. This indicates that the interviewer is to modify the question using the words of the subject to describe the particular symptom. For example, if the subject refers to a manic episode as “when I was wired,” then the interviewer might rephrase the question “Which time were you the most (high/irritable/OWN WORDS?)” to “Which time were you the most wired?”

6. Ratings: Each criterion is coded as either ?, 1, 2, or 3. Following is an explanation of each rating:

\[
? = \text{Inadequate information to code the criterion as either 1, 2, or 3}
\]

A ? should be coded in situations in which there is insufficient information for a more definitive diagnosis. For example, in rating the sleep item for a past Major Depressive Episode, a ? would be
appropriate for a subject who cannot remember whether the episode involved disturbed sleep. In some instances in which diagnostic information is questionable, a ? may be given to indicate uncertainty (for example, a patient denies hallucinations but has been observed to talk to himself in a way that suggests that he may be hearing voices).

When subsequent information makes it possible to recode the criterion, the ? should be crossed out, and a circle made around the correct code. The subsequent information may come from another source, or from the subject later in the same interview, or in a subsequent interview. In some cases, however, such as in the first example above, it may never be possible to obtain the information and the item cannot be used.

1 = Absent or False

Absent: the symptom described in the criterion is clearly absent (e.g., no significant weight loss or weight gain or decrease or increase in appetite).

False: the criterion statement is clearly false (e.g., only one of five required symptoms present; subject has been depressed for only two or three days of two weeks required for a Major Depressive Episode).

2 = Subthreshold

The threshold for the criterion is almost, but not quite, met (e.g., subject has been depressed for only 10 days rather than the required two week minimum; subject reports loss of interest in only some activities, but not the required "almost all activities")

3 = Threshold or True

Threshold: the threshold for the criterion is just met (e.g., subject reports being depressed for two weeks) or more than met (e.g., subject reports being depressed for several months)

True: the criterion statement is true (e.g., "Criteria A, B, and C are coded 3")

7. Providing descriptive information: The interviewer is encouraged to ask the subject to provide specific details of thoughts, feelings, and behaviors in order to
increase the validity of the criterion ratings. This information should be recorded on the SCID in order to document the evidence used to justify the interviewer’s rating. For those criteria in which documentation of specific information is particularly important, the word DESCRIBE: appears below the criterion. This occurs particularly when the question is one that may be misunderstood or interpreted idiosyncratically by the subject. In such situations, it is particularly important for the interviewer to ask for a description of the behavior rather than merely accepting a “yes” answer to a question that may have been misunderstood. When information comes from charts or informants other than the subject, this should also be noted in the SCID.

8. **Skip-outs:** When appropriate, instructions are provided to facilitate skipping over diagnostic criteria that are not relevant for a particular subject. These skip-out instructions come in three basic formats.

   **AT THE BEGINNING OF A SECTION:** Many sections have instructions informing the interviewer of conditions under which the entire section may be skipped. For example, the Dysthmic Disorder section begins with the instruction:

   
   **IF THERE HAS EVER BEEN A MANIC OR HYPOMANIC EPISODE, CHECK HERE AND GO TO NEXT MODULE**

   The interviewer evaluates the conditional statement and, if true, skips to the specified page (in this case, Module B), and continues the SCID at that point.

   **UNDER A SET OF RATINGS:** In these cases, a skip-out instruction is indicated in the right hand column under the codes for rating a criterion. This convention is typically used to enable the interviewer to skip out of a diagnostic section when the entry criterion is judged absent or false. When a code for a criterion leads to a box containing an instruction such as GO TO *DELUSIONAL DISORDER*, C. 15, it tells the interviewer to skip to the specified page number, look in the left-hand column for the location marker, and continue from that point. For example,
means that if a rating of 1 is given, the interviewer should skip to page C.12, look for the location marker "DELUSIONAL DISORDER", and resume asking questions from that point. Note that this does not indicate that the diagnosis is Delusional Disorder, but only that the section in which Delusional Disorder is diagnosed is being considered. In this case, if a rating of 2 or 3 is given, the interviewer should proceed to the next item, in keeping with the SCID rule that unless there is an instruction to the contrary, one should always continue with the next item.

In some cases, the skip-out instruction is dependent on the ratings of more than one criterion. For example, the diagnosis of a Major Depressive Episode requires the presence of either depressed mood (criterion A[1]) or loss of interest or pleasure (criterion A[2]). The vertical line connecting the 1 and 2 ratings for both of these items, followed by the instruction IF NEITHER ITEM (1) NOR ITEM (2) IS CODED "3," GO TO "PAST MAJOR DEPRESSIVE EPISODE, *A. 12," indicates that the interviewer should skip to the past Major Depressive Episode section if both of these criteria are judged not present (i.e., are coded 1 or 2).

**INSTRUCTIONS IN THE LEFT-HAND AND CENTER COLUMNS:** Skip-outs are also indicated by capitalized instructions in the left-hand or center columns. For example, the instruction in the center column of B.2 states:

IF NEVER HAD A PRIMARY DELUSION, AND NO SUSPICION OF ANY PSYCHOTIC FEATURES,
CHECK HERE ___ AND GO TO *AUDITORY HALLUCINATIONS,* B.4

The interviewer must always be on the lookout for skip-out instructions. When there is no skip-out instruction, always proceed to the next question (item).

9. **Summary Score Sheet:** After the interview is completed the interviewer fills out the Summary Score Sheet, located at the front of the SCID.

The diagnostic index in the center column of the Summary Score Sheet indicates the extent to which the criteria for the SCID disorders have been met. Unless otherwise noted, this refers to lifetime prevalence. The levels of this index are defined as follows:

- **?** = Inadequate information to rule in or out a diagnosis of the disorder (e.g., a rating of ? on an exclusion criterion, or on a critical duration criterion).

- **1** = Absent: there is adequate information to judge that the criteria for the disorder are not met and there are few, if any, features of the disorder.

- **2** = Subthreshold: the full criteria are not quite met, but clinically the disorder seems likely (e.g., subject has both depressed mood and loss of interest or pleasure, but only two of the other characteristic symptoms of Major Depressive Episode; subject has two of the three required Manic Episode symptoms). Note that explicit guidelines for a rating of "subthreshold" have not been established for either symptoms or diagnoses and are not provided, thus allowing for clinical judgment.

- **3** = Threshold: the full criteria are met. For most of the Axis I disorders, when a rating of 3 is made, the interviewer goes on to note whether symptoms of the disorder have been present during the past month. Severity scales are provided in the chronology section for most disorders so that a diagnosis can be subclassified as currently mild, moderate, severe, in partial remission, or in full remission.

10. **Multiple clauses:** Note that some of the items consist of two or more clauses. For clauses that are joined by "OR" (e.g., alcohol is often taken in larger amounts OR over a longer period than was intended), a rating of 3 for the full item is made if EITHER of the clauses is judged to be true.

11. **Bracketed questions:** Pairs of mutually exclusive questions are indicated by a bracket connecting the pair of questions on the left-hand side of the page. In such situations, the interviewer decides which of the pair of questions should be
read next by examining the conditions to see which of the two applies. For example, the assessment of Past Major Depressive Episode (page A. 12) begins with the following pair of mutually exclusive questions:

- **IF NOT CURRENTLY DEPRESSED:**
  
  Have you ever had a period when you were feeling depressed or down most of the day nearly every day?

- **IF CURRENTLY DEPRESSED BUT FULL CRITERIA ARE NOT MET,**
  
  SCREEN FOR PAST MDE: Has there ever been another time when you were depressed or down most of the day nearly every day?

This section would be introduced to the subject by reading only one of these two introductory statements, the choice based on whether or not the subject has acknowledged current depressed mood.

12. **Not Otherwise Specified:** The SCID provides a Not Otherwise Specified diagnosis for only the Mood, Psychotic, and Anxiety Disorders. Other cases that would be diagnosed in DSM-IV as NOS (e.g., Eating Disorder NOS) should be classified on the score sheet as Other DSM-IV Axis I Disorders.

13. **Secondary vs. Primary:** Most of the diagnoses covered in the SCID include a criterion that requires the interviewer to decide whether or not the psychopathology is directly due to a general medical condition (GMC) or substance use (i.e., “the disturbance is not due to the direct physiological effects of a substance or general medical condition”). This criterion was known as the “organic” exclusion criterion in DSM-III-R. If the interviewer determines that the disturbance is due to the direct physiological effects of a general medical condition or substance use on the central nervous system, it is considered to be secondary and the SCID directs the interviewer to skip out of the diagnosis being considered and diagnose instead a Mental Disorder Due to a General Medical Condition or Substance-Induced Disorder. In contrast, if the interviewer judges that a general medical condition or substance is NOT the cause of the psychopathology, then the disorder being assessed is primary and the interviewer continues on with the evaluation. For example, in evaluating the criteria for a Major Depressive Episode on page A.4, the interviewer comes to criterion D (“not due to the direct physiological effects of a substance or to a general medical condition”). If the interviewer decides that the depression is secondary to a substance (e.g., cocaine), then a diagnosis of Cocaine-Induced Mood Disorder is made. On the other hand, if the interviewer decides that the
depression is primary, the interview continues on the top of page A.5 with criterion E.

**NEOPHYTE SCIDDERS BEWARE:** The double negative in this criterion is a common source of confusion. The exclusion criterion **IS MET** (coded 3) if the disturbance is **NOT** due to a substance or GMC (i.e., it is primary)--say to yourself “Yes (3), there is no substance or general medical condition.” The criterion is **NOT MET** (coded 1) if it is **NOT TRUE** that the disturbance is not due to a substance or GMC (i.e., it is secondary)--say to yourself “No (1), there is an etiological substance or general medical condition.”

There are two steps to the assessment of whether a disturbance is primary or secondary:

**STEP 1:** Is there evidence that a general medical condition or a substance **MAY** be etiologically associated with the disturbance? If so, further investigate the possibility that the disturbance is secondary by going on to step 2; if not (i.e., the disturbance is primary), rate the criterion 3 and move on to the next item.

Evidence that a general medical condition or substance may be associated includes: 1) the presence of a general medical condition or substance use during the disturbance; and 2) the general medical condition or substance has been reported in the research literature to cause the psychopathology. The questions provided on the left hand side of this criterion serve to establish a temporal relationship and the list of general medical conditions and substances listed below the criterion indicate those conditions and substances that are known to be associated with the psychopathology (at least according to DSM-IV). Note that this list is not exhaustive--many other conditions or medications can cause psychopathology. The interviewer is encouraged to consult with other clinicians or reference sources when in doubt. Once the interviewer has decided that there is evidence of a possible etiological relationship, the box below the criterion instructs the interviewer to skip to the section of the SCID where the Mental Disorder Due to a General Medical Condition or Substance-induced Disorder is evaluated. Let’s say, for example, on page A.4 the interviewer discovers that the individual has been using cocaine around the time of the depressed mood. Since withdrawal from cocaine is well known to cause depression, the interviewer should skip to page A.43 to evaluate whether the criteria for a Cocaine-Induced Mood Disorder are met.

**STEP 2:** Is there evidence for a causal relationship between the disturbance and the substance or general medical condition so that the disturbance can be considered secondary (i.e., are the criteria met for a Mental Disorder Due to a GMC or Substance-induced Disorder)?

The actual clinical judgment about whether the disturbance is primary or secondary is made in the context of evaluating whether the criteria are met for a Mental Disorder Due to a General Medical Condition or a Substance-
Induced Disorder.  (NOTE: For a complete review of how to decide whether a disorder is secondary, see page 44 in the User's Guide for a discussion of the criteria for Mood Disorder Due to a General Medical Condition and page 46 for a discussion of the criteria for Substance-Induced Mood Disorder--these discussions apply as well to psychotic and anxiety disorders due to general medical conditions or substances).  After deciding whether the particular Mental Disorder Due to a GMC or Substance-Induced Disorder is present or absent, the interviewer is instructed to return to the section in the SCID where the “organic” exclusion criterion was being evaluated in the first place in order to complete the rating for that criterion.  If a Mental Disorder Due to a GMC or a Substance-Induced Disorder is diagnosed and it is judged to have completely accounted for the psychopathology, then the disturbance is secondary, the “organic” criterion is rated 1 (i.e., it is NOT true that the disturbance was not due to a GMC or substance) and the interviewer is instructed to skip out.  On the other hand, if the disturbance is primary (i.e., neither a Mental Disorder Due to a GMC nor a Substance-Induced Disorder were present), then the “organic” criterion should be coded 3 (i.e., it is true that the disturbance was NOT caused by a GMC or substance) and the interviewer should proceed to the next item.

An example may help clarify matters: the subject has recurrent unexpected panic attacks.  Criterion C on page F.3 asks the interviewer to consider whether the panic attacks are secondary (i.e., is a GMC or substance use responsible for the condition?).  If the interviewer were to discover that the panic attacks seem to occur only during periods of heavy coffee use, the interviewer would jump to page F.36 to consider whether Caffeine-Induced Anxiety Disorder accounts for the attacks.  If a diagnosis of Caffeine-Induced Anxiety Disorder is ultimately made, then, upon returning to the evaluation of criterion C for Panic Disorder, the interviewer would rate it as not present (code 1) and skip to Agoraphobia Without History of Panic Disorder.  Otherwise, if the panic attacks are primary (i.e., in the absence of a substance or GMC etiology), the interviewer continues with criterion D.

If the interviewer knows from the overview that the diagnosis is likely to be excluded because of an etiological GMC or substance use, he or she may skip directly to the rating of the criterion for the Mental Disorder Due to a GMC or Substance-Induced Disorder, rather than spending a lot of time documenting a syndrome that is going to be ultimately excluded on the basis of a general medical or substance etiology.  For example, if the subject has described being depressed during a few months when he or she was taking steroids, the interviewer may ask whether that was the only time the subject has ever been depressed.  If that was the only time, the etiological GMC/substance criterion for Past Major Depressive Episode may be coded 1, and the interviewer should proceed as instructed (i.e., skip to page A.18, Current Manic Episode).

14. Consideration of treatment effects: Symptoms should be coded as present or absent without any assumptions about what would be present if the subject were not receiving treatment.  Thus, if a patient is taking 1000 mg. of chlorpromazine and no longer hears voices, auditory hallucinations should be coded as currently
absent, even if the interviewer believes that without the medication the hallucinations would probably return. Similarly, if a subject is taking a sedative every night and no longer has insomnia (initial, middle, or terminal), insomnia should be coded as currently absent.

15. **Chronology sections:** Most disorders in the SCID conclude with a chronology section (e.g., for Panic Disorder, see page F.6). In most cases, the first rating in the Chronology section indicates whether or not the disorder is “current.” For most disorders, the diagnosis is “current” if the full criteria have been met for the disorder at any point during the past month. Note that for those disorders that require a minimum duration of symptoms (e.g., two consecutive weeks for a Major Depressive Episode), the disorder is considered current if the full syndrome extends into the current month (e.g., a Major Depressive Episode that started 5 weeks ago and went into partial remission after only 2 weeks would be considered “current”). If the disorder is rated 3 for current, the interviewer must then rate the current severity (e.g., mild, moderate, severe). If criteria are not currently met, then the interviewer must indicate both the type of remission (e.g., partial remission, full remission, prior history) and the number of months prior to the interview in which any symptoms of the disorder were present. Finally, the interviewer indicates the age at onset, defined as the age at which any symptoms of the disorder first appeared.

16. **Clinical Significance:** Most disorders in the SCID include a criterion that requires there to be clinically significant distress or impairment before a DSM-IV diagnosis can be made. For most subjects in psychiatric settings, this judgment is a non-issue since there is implied clinical significance by virtue of the fact that the subject is a patient. This criterion is more important (and more difficult to evaluate) in the SCID-NP because the subjects are not identified as psychiatric patients. Note that there are two components, distress and impairment, either of which indicate clinical significance. Seeking treatment is certainly evidence of significant distress. Impairment may involve, for example, lost days at work or school, or disruption of relationships.

17. **Use of Screening Questions in Overview:** The Overview section of the SCID concludes with an optional screener containing twelve screening questions. These questions are taken from the body of the SCID and are the initial questions asked by the SCID for the disorders being screened. These screening questions may help reduce the potential effects of a "negative response bias" that may be especially problematic in the later sections of the SCID. Because of the structure of the SCID, there is a tendency for the subject to notice that a YES answer to the initial probe question in a section results in follow up questions, whereas a NO answer results in a skip to the next section, thus leading some subjects to give NO answers as a way of speeding the interview along. By asking these questions up front and using the answers to these questions in the determination of whether a section should be skipped, response bias may be minimized.
On the two pages that follow the Overview section, you are instructed to ask the twelve questions without any follow-up or elaboration. You will have the opportunity to ask the subject additional follow-up questions later, in the section of the SCID in which the disorder is being considered. Therefore, when the subject gives a positive response to one of these screening questions, you should explain "We'll talk more about that later." A NO answer should be coded as a 1, an equivocal response as a 2 and a YES response coded as a 3. At the end of the overview, the appropriate YES/NO boxes corresponding to each screening question should be filled in before proceeding further in the SCID. (These boxes are located on the upper right hand corner of the indicated pages). When you actually reach the YES/NO boxes in the body of the SCID, you will be instructed to either skip the module (if the screening question was answered NO) or else ask some follow-up questions. For these screening questions (as with all questions in the SCID), if you think that you already know the answer to the question, you should rephrase it as "You've said______: is that right?"

9. SCID DO'S AND DON'T'S

⇒ DO give the subject a brief explanation of the purpose of the interview before beginning. In research studies this will usually be part of obtaining informed consent.

⇒ DON'T apologize for using a structured interview. ("I have to read these questions. Most of them won't apply to you. Just bear with me." "I have to give this standardized interview.") When the SCID is properly administered, it is a clinical interview and needs no apology. In fact, most subjects appreciate the thoroughness of the SCID and welcome the opportunity to describe their symptoms in detail.

⇒ DO use the Overview to obtain the subject's perception of the problem. (The Overview may also be used to collect information that is needed for a specific study but not covered in the SCID, such as family history.)

⇒ DON'T ask in detail in the Overview about specific symptoms that are covered in the later sections of the SCID.

⇒ DO get enough of an overview of the current illness at the beginning of the interview to understand the context in which the illness developed.

⇒ DON'T ask the specific questions about symptoms after a perfunctory overview of a current illness.
⇒ **DO** stick to the initial questions, as they are written, except for necessary minor modifications to take into account what the subject has already said, or to request elaboration or clarification.

⇒ **DON'T** make up your own initial questions because you think you have a better way of getting at the same information. Your minor improvement may have a major unwanted effect on the meaning of the question. A lot of care has gone into the exact phrasing of each question and they work in nearly all cases.

⇒ **DO** ask additional clarifying questions in order to elicit details in the subject’s own words, such as ”Can you tell me about that?” or ”Do you mean that....?”

⇒ **DON'T** use the interview as a checklist or true/false test.

⇒ **DO** use your judgment about a symptom, taking into account all of the information available to you, and confronting the subject (gently, of course) about responses that are at odds with other information.

⇒ **DON'T** necessarily accept a subject's response if it contradicts other information or you have reason to believe it is not valid.

⇒ **DO** make sure that the subject understands what you are asking about. It may be necessary to repeat or rephrase questions or ask subjects if they understand you. In some cases it may be valuable to describe the entire syndrome you are asking about (e.g., a manic episode).

⇒ **DON'T** use words that the subject does not understand.

⇒ **DO** make sure that you and the subject are focusing on the same (and the appropriate) time period for each question.

⇒ **DON'T** assume that symptoms that a subject is describing cluster together in time unless you have clarified the time period. For example, the subject may be talking about a symptom that occurred a year ago and another symptom that appeared last week, when you are focusing on symptoms that occurred jointly during a two-week period of possible Major Depressive Episode.
⇒ **DO** focus on obtaining the information necessary to judge all of the particulars of a criterion under consideration. As noted above, this may require asking additional questions.

⇒ **DON'T** focus only on getting an answer to the SCID question.

⇒ **DO** give the subject the benefit of any doubt about a questionable psychotic symptom by rating either 1 or 2.

⇒ **DON'T** call a subculturally accepted religious belief or an overvalued idea a delusion. **DON'T** confuse ruminations or obsessions with auditory hallucinations.

⇒ **DO** make sure that each symptom noted as present is diagnostically significant. For example, if a subject says that he has *always* had trouble sleeping, then that symptom should not be noted as present in the portion of the SCID dealing with the diagnosis of a Major Depressive Episode (unless the sleep problem was worse during the period under review). This is particularly important when an episodic condition (such as a Major Depressive Episode) is superimposed on a chronic condition (such as Dysthymic Disorder).

⇒ **DO** pay attention to double negatives, especially in the exclusion criteria (i.e., is **NOT** better accounted for by Bereavement) means that a rating of 1 is made if it is better accounted for by Bereavement, and a 3 if it is **NOT**.

⇒ **DON'T** code 1 for an exclusion criterion when what you really mean is that the excluded item is **NOT** present (e.g., if the criterion reads "**NOT** due to the direct physiological effects of a general medical condition or substance," then a rating of 1 means that the disturbance is secondary, i.e., due to a general medical condition or substance, and a rating of 3 means primary—**NOT** due to a general medical condition or substance). (Think: "Yes, we have no bananas" -- "3, we have no etiological medical conditions or substances.")

⇒ **DO** make diagnoses according to the criteria in the SCID, and record these on the Summary Score Sheet.

⇒ **DON'T** make a diagnosis that you think is correct but is not made according to SCID rules. (Your own diagnosis, if it differs from the SCID diagnosis, can be noted at the end of the Summary Score Sheet.)


⇒ **DO** proceed sequentially through the SCID unless an instruction tells you to skip to another section.

⇒ **DON’T** skip over a section without filling anything in because you are certain that it does not apply--e.g., don’t skip the psychotic symptoms section because you are sure from the overview that the subject has never had psychotic symptoms.

⇒ **DO** select the coding options that are presented.

⇒ **DON’T** record illegitimate write-in votes, such as a 2 when the choices are 1 or 3.

### 10. SPECIAL INSTRUCTIONS FOR INDIVIDUAL MODULES

This section of the User’s Guide provides specific instructions for each of the individual SCID modules.

#### 10.1 SCORE SHEET

The score sheet is arguably the most important single module of the SCID since, in practice, it is the score sheet that is used as the source of diagnostic information for data analysis. No matter how carefully the interview was done, a mistake or omission on the score sheet will result in erroneous diagnostic data.

#### 10.1.1 SCORING THE INDIVIDUAL DISORDERS

The score sheet lists the Axis I Disorders included in the SCID in turn, each preceded by a two-digit number used for indicating which diagnosis is “principal” (see below). For most SCID diagnoses, a rating is made in the center column indicating the lifetime prevalence: 3 is circled if the full criteria for the disorder have ever been met at any point in the individual’s lifetime; 2 is circled if most, but not all, of the criteria have ever been met, and 1 is circled if the criteria have never been met. For any disorder rated 3, an additional rating is made in the right hand column of the scoresheet indicating whether the criteria for the disorder are currently met (i.e., met at any time during the last month). For those diagnoses that are made only if present currently (i.e., Dysthymic Disorder, Generalized Anxiety Disorder, Somatoform Disorders, Adjustment Disorder) the rating in the center column indicates instead that the criteria were met during the
past month. Subtypes and specifiers are indicated by circling the appropriate numbers below the disorder.

Because of the comprehensive nature of the SCID evaluation, it is not uncommon for more than one DSM-IV disorder to be diagnosed. In such situations, it is often useful to designate one of them as the "principal diagnosis," i.e., the disorder that was the main reason for the current clinical encounter. This is indicated by noting the two-digit SCID diagnosis number listed on the left-hand side of the principal diagnosis (e.g., 04 for Major Depressive Disorder).

Mood Disorder Due to a General Medical Condition, Substance-Induced Mood Disorder, Psychotic Disorder Due to a General Medical Condition, Substance-Induced Psychotic Disorder, Anxiety Disorder Due to a General Medical Condition, and Substance-Induced Anxiety Disorder include the instruction "specify:____". This indicates that the specific etiological substance or general medical condition should be noted.

10.1.2 SCORING DSM-IV AXIS IV

DSM-IV Axis IV is for noting clinically relevant psychosocial and environmental problems that may be important in the clinical management of the individual. Problem areas are presented in a checklist format in order to insure a comprehensive evaluation. The interviewer should check any relevant problem areas and then specify the particular type of problem (e.g., unemployment, divorce). In most cases, information gathered during the course of the SCID (especially from the last section of the Overview) is sufficient for recording Axis IV. If not, additional questions should be improvised as needed (e.g., "Does your depression put a major strain on your relationship with your wife?").

10.1.3 SCORING DSM-IV AXIS V

An Axis V evaluation entails rating the subject using the Global Assessment of Functioning (GAF) Scale. To make a GAF rating, the interviewer chooses a single value that best reflects the subject's current overall level of functioning. The GAF Scale is divided into ten ranges of functioning. The description of each range in the GAF has two components: the first part covers symptom severity and the second part covers functioning. The GAF rating is within a particular decile if EITHER the symptom severity OR the level of functioning falls within the range. For example, the first part of the description of the range 41-50 indicates "serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting)" and the second part "any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job)." The GAF Scale is thus really like two scales wrapped into one: one scale for measuring symptom severity and another scale for measuring the level of functioning. Note that the SCID has a provision for two GAF ratings: current (lowest level in the past month) and highest GAF score achieved over a
particular period of time (which can be helpful in indicating the individual’s potential level of functioning once the disorder remits).

**FOUR STEPS TO AN AXIS V RATING**

**STEP 1:** Starting at the top level, evaluate each range by asking yourself, “Is EITHER the subject’s symptom severity OR the subject’s level of functioning worse than what is indicated in the range?”

**STEP 2:** Keep moving down the scale until you reach the range that best matches your subject’s symptom severity OR the level of functioning, WHICHEVER IS THE WORST.

**STEP 3:** The range immediately BELOW the range you’ve picked in step 2 should be too severe for BOTH symptom severity AND level of functioning. If not, you stopped too soon and should keep moving down the scale.

**STEP 4:** To determine the specific number within the 10-point range, consider whether the patient is functioning at the higher or lower end of the range.

An alternative method is to treat the GAF as if it were two scales: one for symptom severity and another for level of functioning. Using the steps above, make one rating for severity and a second for level of functioning. The WORST of the two can be used as the GAF.

**10.2 OVERVIEW**

This module allows the interviewer to obtain enough information to make a tentative differential diagnosis before inquiring systematically about specific symptoms in the later modules. The Overview in the SCID-P is divided into two sections: present illness or exacerbation, and history of prior mental illness. This division works quite well when the subject has a current episode of illness that is distinct from prior episodes. When there is a chronic disorder with periods of partial remission and exacerbation (e.g., chronic Major Depressive Disorder), the interviewer must make a clinical decision about what constitutes the current period of illness. Often this judgment will be based on information about when there was a gross change in functioning (e.g., had to quit job, dropped out of school). The sequence of questions in the overview will not flow as smoothly if the current illness is not clearly distinguishable from chronic or recurrent problems, and the interviewer may have to improvise questions to elucidate the complete clinical course.

The Overview in the SCID-NP does not assume a chief complaint (current illness) and inquires about emotional problems and any treatment that the individual may have ever had. If the subject has never had any kind of
psychiatric treatment, two questions in the overview are particularly important for locating periods of possible lifetime mental disorders: 1) Has there ever been a time when the subject was unable to go to work or school? and 2) When, in his or her life, was the subject most upset?

When asking about a history of past treatment and it becomes clear that the subject has had a particularly complicated history, it may be useful to turn to the Life Chart, located at the end of the Overview. This chart provides a framework for recording past treatment history in a chronological fashion.

When the SCID is used to interview subjects with psychotic symptoms, it is often necessary to use ancillary information to elicit responses in the Overview. For example, if a subject has no chief complaint and denies having any idea of why he or she was brought to a psychiatric unit, the interviewer might say: "The admission note said you were burning your clothes in the bathtub, and your mother called the police. What was that all about?" In many cases in which the patient is currently psychotic, most of the information may have to come from the chart or from other informants.

In the Overview, subjects are asked about all past treatments, including medications. The interviewer should be sure to question a subject about any medications that were prescribed that do not seem appropriate for the condition described. This often gives a clue to problems that the subject has not mentioned. For example, a subject who describes only chronic depression, but was treated with lithium in the past, may describe a possible manic episode when asked why lithium was prescribed. (Of course, a prescribed medication should NOT be used to justify a diagnosis without documentation that the disorder actually met criteria, since medication is sometimes prescribed inappropriately.)

The Overview concludes with an optional screener containing twelve screening questions. See page 22 of the User’s Guide for specific instructions.

10.3 MODULE A. EVALUATION OF MOOD EPISODES, DYSTHYMIC DISORDER, MOOD DISORDER DUE TO A GMC, AND SUBSTANCE-INDUCED MOOD DISORDER

This module begins with ratings for Major Depressive Episode, Manic Episode, and Hypomanic Episode. Please note that the ratings for those disorders that are defined by the presence (or history) of one or more of these episodes are made in later modules (i.e., Module C for Schizoaffective Disorder and Module D for Major Depressive Disorder, Bipolar I Disorder, and Bipolar II Disorder). Also note that this is the only module in the SCID in which there are separate sections for current (past month) and past episodes.
Ratings for Current Major Depressive Episode (A.1-A.5)

Criterion A:  Establishing the Minimum Two Week Duration: When the interviewer begins to ask about a possible Major Depressive Episode, the first task is to determine whether there has been a two-week period of depressed mood and/or loss of interest that has occurred in the last month (or had an earlier onset but persisted into the past month). If there is some doubt about whether the duration of the depressed mood is truly two full weeks, the interviewer should inquire about the specific symptoms anyway, because it often turns out that a subject who minimizes a problem when first asked may, on further reflection, recall that he or she was, in fact, symptomatic for a full two weeks.

Establishing Co-occurrence of Symptoms During the Same Two-Week Period: Once it has been determined that depressed mood or loss of interest has persisted for at least two weeks, the next task is to determine whether at least 4 additional symptoms have occurred most of the day, nearly every day, during the same two-week period of time. This is done by first establishing with the subject a “target” two-week period in the past month and then making sure that the subject is aware that the questions refer only to this two-week period. Any two-week period in the past month can serve as the target—it is generally recommended that you focus on what the subject perceives as the worst two weeks in the past month. If the subject reports that the depressed mood has been pretty much the same for the entire month, the interviewer should focus on the most recent two weeks.

COMMON PITFALLS: One of the most common errors made in this section is the failure of the interviewer to insure that each symptom has been present for “most of the day, nearly every day.” We therefore strongly recommend that you specifically ask, “Was that true for most of the day, nearly every day, during this period?” after each symptom, even to the point of tedium, since there is no other way to insure that this duration requirement is met. Do not just assume that if the first several symptoms are present for most of the day, nearly every day, that the rest will also have this pattern. Note that item A(9) does not have to be present every day--recurrent suicidal ideation or a single suicide attempt alone warrants a rating of 3.

A second common pitfall is to forget to ask about the second half of an item when the subject answers “no” to the first part. For example, item A(7) can be rated 3 if EITHER worthlessness OR excessive or inappropriate guilt has been present. If the subject denies feelings of worthlessness, then the interviewer should NOT code the item a 1 but must follow-up that question with an inquiry about excessive or inappropriate guilt. For those SCID users interested in BOTH halves of the items (e.g., wanting to record both worthlessness and guilt), then both parts should be asked, regardless of the response to the first part of the item.
A third issue is how to count symptoms that occur in the context of a co-morbid general medical condition. General medical conditions may present with the same types of symptoms as characterize a depressive episode (e.g., weight loss, insomnia, fatigue). Should they be attributed to the depression or the medical condition? The rule in DSM-IV is to consider such symptoms as part of the depressive episode UNLESS they are clearly attributable to the medical condition. For example, insomnia related to frequent nocturnal coughing spells in a person with bronchitis should not count for item A(4). Similarly, symptoms should not count toward Major Depressive Episode if they are better accounted for by another disorder. For example, weight loss due to refusal to eat food because of the delusion that the food is poisoned should not be rated 3.

A final issue is whether to consider as part of the depressive episode symptoms that have been present prior to the onset of the episode (e.g., chronic insomnia). Such symptoms count toward a diagnosis of a Major Depressive Episode only if they have become appreciably worse during the depressive episode. For example, if an individual who usually takes 30 minutes to fall asleep finds that it has been taking two hours to fall asleep since the episode began, it would make sense to rate item A(4) as present for the episode.

**Criterion A(1):** Depressed mood may be acknowledged directly (“I’ve been feeling depressed”) or by one of its many synonyms (sad, blue, tearful, “down in the dumps,” “I can’t stop crying”). Depressed mood in a Major Depressive Episode can be distinguished from “ordinary” (i.e., nonpathological) depression only by virtue of its persistence and severity. To count toward this criterion, the subject’s depressed mood must have been present for most of the day, nearly every day, for at least two weeks. Note that the criterion can be rated 3 based on observational information, even if it runs counter to the subject’s subjective reporting (e.g., a stoic elderly patient denies being depressed whereas the staff reports that the patient has been continuously tearful).

**Criterion A(2):** Although the cardinal symptom of a Major Depressive Episode is depressed mood, it may be diagnosed in the absence of a subjective feeling of depression. Some subjects, particular those with severe presentations, have lost the capacity to feel sadness. Others may have a cognitive style or come from a cultural setting in which feelings of sadness are downplayed. For such subjects, loss of interest or pleasure counts as a “depressive-equivalent” and can be substituted for depressed mood when defining the two-week interval that applies to criteria A(3)-A(9). Evidence of this symptom may be that the subject reports a general diminishing of pleasure (e.g., nothing makes me happy anymore) or specific examples such as no longer reading books, watching TV, going to the movies, socializing with friends or family, or having sex. When rating this item, note that complete loss of interest or the ability to experience pleasure is not necessarily required for a rating of 3—evidence that there is a significant reduction in the ability to experience pleasure will suffice.
**Criterion A(3):** This item is rated 3 if there has been a significant change in appetite, either up or down, OR a significant change in weight during the two-week target period. Note that the first part of this item focuses on appetite and not on the amount of food consumed; thus a rating of 3 should be made only if the subject acknowledges a significant change in his or her appetite for food. Since this is a compound item requiring a change in either appetite or weight, one need inquire about weight change only if there is no significant change in appetite. (Be forewarned, however, that significant changes in weight without corresponding appetite changes suggest the possibility that a general medical condition may be responsible for the change in weight.)

**Criterion A(4):** Insomnia may be manifested in many different ways, any one of which can count for this item. These include difficulty falling asleep, waking up a number of times in the middle of the night, and awakening much earlier than is normal for that person, with an inability to fall back asleep. Hypersomnia is sleeping much more than is normal for the person. Note that it is difficult and potentially not very meaningful to establish an absolute definition of the number of hours of sleep that constitute insomnia or hypersomnia because of wide variability in individuals’ need for sleep. However, as a rule of thumb, sleeping two hours more or less than is typical on a daily basis would constitute hypersomnia or insomnia. Note that hypersomnia should not be coded for someone who stays in bed for most of the day but is not sleeping.

**Criterion A(5):** Psychomotor agitation and retardation refer to changes in motor activity and rate of thinking. While many depressed subjects describe a subjective feeling of being restless or slowed down, this item should not be counted unless the symptoms are visibly apparent to an outside observer (e.g., the subject is either pacing and unable to sit still, or seems to move in slow motion). If the symptom is not currently present and observable by the interviewer, there must be a convincing behavioral description of past agitation or retardation that was observed by others. Distinguish the feelings of being slowed down in psychomotor retardation (e.g., “I feel like I’m walking through a vat of molasses”) from feelings of having no energy, which are coded in the next item.

**Criterion A(6):** Subjects with this symptom may report feeling tired all the time, “running on low power,” feeling “weak” or totally drained after minimal physical activity. When a subject complains about not feeling like doing anything, the interviewer should differentiate between lack of energy and loss of interest or motivation, which may also be present.

**Criterion A(7):** Be careful in rating this item since subjects who are depressed but who do not have the full syndrome of Major Depressive symptoms often acknowledge feeling bad about themselves or feeling guilty. The actual item requires a more severe disturbance in self-perception--either feelings of **worthlessness** OR excessive or **inappropriate** guilt. If, after asking a subject
how he or she feels about himself or herself, you get an "I feel bad" or "I don’t like myself," it is often helpful to present the subject with the actual item (e.g., "How bad does that get? So bad that you feel worthless?"). Similarly, while subjects often report feeling guilty about the negative impact their problems have on others ("I feel so guilty for being such a burden"), such feelings are often not excessive or inappropriate. A true positive response requires evidence of exaggerated and inappropriate guilt (e.g., "I feel like I’ve ruined my family forever").

**Criterion A(8):** Cognitive impairment in depression is sometimes severe enough to resemble dementia. With less severe, but still significant, impairment, a patient may be unable to concentrate on any activity (e.g., watching TV, reading a newspaper) due to an inability to filter out brooding thoughts. Interviewers should note that the impairment caused by this symptom may vary depending on the patient’s baseline. For example, a theoretical mathematician may still be able to watch TV but no longer be able to concentrate on mathematical proofs--in such an instance, a rating of 3 would be warranted. Note that the second half of this item taps a different type of impairment (i.e., indecisiveness). A subject suffering from this symptom may report feeling paralyzed by even simple decisions, like which clothes to wear for the day or what to eat for lunch.

**Criterion A(9):** This is the only symptom that does not have to be present nearly every day for at least two weeks to warrant a rating of 3. Any recurrent suicidal thoughts or behavior or any single suicide attempt is sufficient, as well as frequent thoughts such as: “I’d be better off dead.” or “My family would be better off if I were dead.” If there are current suicidal thoughts, it is imperative that the interviewer explores the seriousness of these thoughts and takes appropriate action, which may include informing the clinician in charge.

Self-mutilating behavior (cutting, burning, etc.) without suicidal intent that is only an expression of anger or frustration or is done with the aim of controlling anxiety, is coded 1.

[Note: DSM-IV criterion B, which excludes a diagnosis of Major Depressive Episode if criteria are also met for a mixed episode has been omitted since Mixed Episodes are coded in the SCID as simultaneous Manic and Major Depressive Episodes.]

**Criterion C: Clinical Significance:** DSM-IV has added this "clinical significance" criterion to most of the disorders in order to emphasize the requirement that a symptom pattern must lead to impairment or distress before being considered diagnosable as a mental disorder. These criteria have been included in the SCID for the sake of completeness and we imagine that it will only rarely be necessary to ask the corresponding question. This criterion may help the interviewer make a decision as to whether a diagnosis should be made, particularly in studies of non-patients for whom the severity of the presentation is near the symptomatic threshold for a disorder,
**Criterion D:** This criterion instructs the interviewer to consider and rule out a general medical condition or a substance as an etiological factor. See page 19 for a general discussion of how to apply this criterion, and pages 44 and 46 for a discussion of the criteria for Mood Disorder Due to a General Medical Condition and Substance-Induced Mood Disorder.

**Criterion E: Ruling Out Simple Bereavement.** At this point in the SCID, a depressive period lasting at least two weeks has been identified. If, however, that depressive period is considered to be a normal and expectable reaction to the death of a loved one, it is not diagnosed as a Major Depressive Episode but would instead be Bereavement. Therefore, the judgment required in this item is whether the depressive reaction has crossed the line (in terms of persistence and severity) from Bereavement to Major Depressive Disorder. DSM-IV provides two guidelines for diagnosing Major Depressive Disorder rather than Bereavement: 1) if the depressive symptoms (i.e., at least 5, most of the day, nearly every day) have persisted for at least two months following the loss, or 2) if certain depressive symptoms that are particularly uncharacteristic of Bereavement are present (e.g., suicidal ideation, psychomotor retardation, etc.). *Note that this is one of those double negative items, i.e., a 3 is coded if it is NOT better accounted for by Bereavement (“Yes, we have NO Bereavement”), and a 1 is coded if it IS.*

**Number of Episodes.** After making a rating of 3 indicating that the criteria are met for a current Major Depressive Episode, the interviewer is instructed to make a rough estimate about the number of episodes. This entails asking the subject to report how many separate times he or she has had a Major Depressive Episode—it does not mean that the interviewer has to inquire about each symptom for each episode. For most purposes, an estimate of the number of episodes will be sufficient. However, investigators interested in the specific symptom patterns characterizing each past episode may wish to turn to Module J in order to document the details of past Major Depressive Episodes.

**Episode Specifiers:** The ratings for Current Major Depressive Episode conclude with criteria sets for With Postpartum Onset, With Catatonic Features, With Melancholic Features, and With Atypical Features. All four should be considered for a current mood episode ONLY. If the interviewer wishes to bypass the rating of these specifiers, the interview should be continued on page A.18 (Current Manic Episode).

**WITH POSTPARTUM ONSET:** This specifier applies if the current Major Depressive Episode has its onset within 4 weeks of delivery. In DSM-IV, the term “postpartum” generally refers to the period after a birth, not a miscarriage or abortion.
WITH CATATONIC FEATURES: These criteria are almost always coded based on historical information from other informants or after a review of prior records, since subjects with catatonia are unable to provide such information firsthand. Some of these items are relatively specific for catatonia and are easy to identify (e.g., (4) peculiar behavior, and (5) echolalia). Other symptoms, like catatonic excitement and catatonic immobility differ only in degree from mood symptoms such as agitation and retardation. For example, slowing down of movements that causes a person to spend two hours getting dressed would be evidence for psychomotor retardation, whereas complete immobility for several hours would be considered catatonia.

WITH MELANCHOLIC FEATURES: The co-occurrence of these symptoms during a Major Depressive Episode identifies a particularly severe form of depression that may be more likely to respond to biological treatment. This subtype applies to the worst period of the current episode that may or may not have occurred during the past month. Since some of these symptoms (e.g., A(1), B(4), B(5), and B(6) are part of the nine items for Major Depressive Episode, the interviewer may be able to rate them without asking the subject any further questions if the worst period corresponds to the period that the interviewer inquired about during the evaluation of the current Major Depressive Episode. Note, however, that A(1), B(4), and B(5) in With Melancholic Features (i.e., "loss of interest...", "marked psychomotor retardation," and "significant anorexia") are each more severe than the corresponding items in Major Depressive Episode so that additional questions may be required to ascertain that the symptom is present at the appropriate level of severity. Item B(6) ("excessive or inappropriate guilt") may necessitate further questions if the subject endorsed "feelings of worthlessness" for the corresponding Major Depressive Episode item A(7).

The remaining items are specific to Melancholic type. The lack of reactivity in Item A(2) characterizes depression that seems to have a life of its own in that it does not change in response to events that would normally make the subject feel good. For item B(1), the subject must report that the depression feels qualitatively different from "normal" sadness. Some patients report it feeling like "being in a fog" or like being physically ill.

WITH ATYPICAL FEATURES: This specifier can be diagnosed only if the current episode has not been characterized by With Catatonic Features or With Melancholic Features. In contrast to With Melancholic Features, in which there is often a non-reactive mood, With Atypical Features requires that the depression be reactive, i.e., the mood brightens in response to actual or potential positive events. Patients with atypical features are often exquisitely sensitive to good or bad news. In fact, episodes are often triggered by an interpersonal loss (e.g., breakup of a love affair), and improve dramatically when the loss is reversed (e.g., beginning a new relationship). The characteristic vegetative symptoms are in the opposite direction of those experienced in melancholia. Instead of insomnia and anorexia, there is often hypersomnia and overeating (particularly of
sweets). Unlike the other criteria that describe “state” symptoms that cluster together during the same two-week period, criterion B(4) describes a “trait” symptom (i.e., hypersensitivity to interpersonal rejection) that is present not just during episodes of mood disturbance.

Stewart and others (Stewart, et al., 1993) at the Depression Evaluation Service at New York State Psychiatric Institute have operationalized the items as follows: **Mood reactivity:** a 50% improvement in mood; **Significant weight gain or increase in appetite:** 10-15 pound increase in past three months; wants to binge at least 3 times per week or urge to overeat at least 5 days per week; **Hypersomnia:** sleeping at least 10 hours per day for at least 3 days per week; **Leaden paralysis:** at least an hour a day, 3 days per week.

**Ratings for Past Major Depressive Episode (A.12-A.15)**

If the symptoms do not meet criteria for a current episode, the interviewer inquires in detail about any past periods of depressed mood or loss of interest. Because of the difficulty that some subjects may have in recalling specific symptoms that characterized a depressive episode occurring years earlier, the interviewer should pick a specific two week interval during the depressive period to be the focal point for the subsequent eight questions. We recommend using holidays, seasons, or other life events (e.g., birthdays, graduation) as “landmarks” in trying to narrow down the two-week period in which the depression was the worst. This process of carefully reviewing the subject’s past also serves to transform the time period from an abstraction to a more vivid memory so that the reporting of specific symptoms is more likely to be valid. For example, let’s say a subject reports being depressed for several months during his junior year in college. The interviewer may try to pinpoint a two-week interval as follows: “I know it’s hard to be this precise, but I need to focus on a two week period when it was the worst. Were you depressed during the fall semester of your junior year, or in the spring?” Subject answers “spring,” “Was it before or after spring break?” “How close was it to finals?” etc.

In those situations in which the subject reports more than one past episode in his or her lifetime, the interviewer should establish which of the episodes was “the worst,” and subsequent questions should focus on the worst two-week period during that “worst” episode. However, there are a couple of exceptions to this rule. If there has been an episode in the past year, the interviewer should ask about this period even if it was not “the worst,” because it is more recent, and therefore the subject is more likely to remember it well. In addition, when there are several possible episodes to choose from, experienced interviewers may want to avoid focusing on an episode that is likely to be ruled out because of a possible etiological GMC or substance or because it may be better accounted for by Bereavement. **REMEMBER that ratings for Past Major Depressive Episode are made ONLY IF the criteria are not met for a current Major Depressive Episode.**
**Criterion A(1):** Note that the specific wording for the introductory question depends on whether the initial question (corresponding to criterion A(1)) for Current Major Depressive Episode (page A.1) was answered YES. If it were, then the wording for this question must be adjusted to indicate that it refers to ANOTHER time when the subject may have been depressed. If the original question on page A.1 was answered NO (i.e., no significant depression in past month), then the question is whether there was EVER a time when the subject was depressed.

**Criteria A(2)-D:** The remaining items are identical in content to their counterparts in Current Major Depressive Episode. The main difference between the evaluation of a past vs. current episode is what happens when the interviewer codes a 1 for items A75-A78. When rating a current episode, the interviewer is instructed to skip to the evaluation of past Major Depressive Episodes when a rating of 1 is made, since that rules out a Current Major Depressive Episode. In contrast, when a rating of 1 is made during the evaluation of a past episode, the interviewer is instructed to consider whether there may be any other periods of depression that are more likely to meet the criteria for a Major Depressive Episode before skipping to the evaluation of a Current Manic Episode. Although presumably the interviewer has already inquired about past episodes and chose to focus on the “worst” one during the initial evaluation of past episodes (see above), the question is included as a double check to make sure no other likely candidate episodes are skipped. There are two circumstances when this is most likely: 1) if the interviewer decided to focus on an episode in the last year rather than the “worst” in the person’s life; or 2) if the subject’s concept of “worst” refers to specific symptom severity or change in functioning rather than the total number of symptoms.

**Major Depressive Episode in Partial Remission.** Sometimes a subject is interviewed with the SCID when a Major Depressive Episode is partially remitted. For example, two months ago the subject may have been depressed with persistent loss of interest, insomnia, poor appetite, low energy and thoughts of suicide. At the time of the SCID interview his depressed mood and loss of interest persists, but he is now sleeping better, his appetite is back, and he no longer thinks of suicide. His symptoms do not meet criteria for current Major Depressive Episode (past month), but do meet criteria for past Major Depressive Episode. On the scoresheet such a subject’s condition is coded 3 for lifetime Major Depressive Disorder, but 1 for “Meets Criteria Past Month.” In the chronology section, “In Partial Remission” is coded.

**Ratings for Current Manic Episode (A.18-A.21)**

This section begins with an instruction that allows the interviewer to skip to the ratings for past Manic Episode if there is no evidence for a current Manic Episode. Remember that for the purposes of the SCID, “current” refers to
the entire past month so that the subject does not have to appear manic during the interview to have a current Manic Episode. Furthermore, a current Major Depressive Episode does not disqualify the subject from also having a current Manic Episode. Such cases are called Mixed Episodes in DSM-IV and are coded when rating the current type of Bipolar I Disorder in Module D.

**Criterion A: Elevated or Irritable Mood:** This criterion requires a persistently elevated, expansive or irritable mood. Subjects often describe periods of irritability that are clearly not associated with a Manic Episode. Most commonly, such periods are either Major Depressive Episodes with irritability as an associated feature, or chronic irritability that is a symptom of a personality disturbance. However, if there is any question whether the irritability might be part of a Manic or Hypomanic Episode, the interviewer should continue to ask all the manic questions in order to make a judgment as to whether the irritability is a symptom of a Manic or Hypomanic Episode or is better accounted for by another condition.

**Criterion A: One Week Duration:** The criteria sets for Manic and Hypomanic Episode are symptomatically identical but differ in terms of minimum duration (Manic Episode has a minimum duration of one week whereas a Hypomanic Episode has a minimum duration of only four days) and severity (Manic Episodes cause significant impairment in functioning whereas a Hypomanic Episode by definition must NOT cause significant impairment). If the duration of the elevated/irritable mood is less than one week, then the interviewer is instructed to skip to page A.24 to check for a current Hypomanic Episode.

**Criterion B(1):** It is important to remember that in order to count a B symptom toward the diagnosis of a Manic Episode, the symptom must be present during the period of elevated or irritable mood and must be persistent and clinically significant. Therefore, merely being more self-confident than usual would not suffice for a rating of 3. There must be grandiosity or inflated self-esteem that is clearly not justified by a realistic evaluation.

**Criterion B(2):** The subject should report getting by on 2 (or more) hours less sleep than usual in order to justify a rating of 3 for this item. The prototypic patient feels that he or she does not need to sleep at all. While some individuals may report waking up and not feeling tired, more commonly the individual describes feeling driven or “wired” and cannot calm down enough to sleep.

**Criterion B(3):** The increase in talkativeness is manifest in both the rate and amount of speech. The speech often has a driven quality, as if there is so much to say and not nearly enough time to say it. If present during the interview, it may be very difficult for the interviewer to interrupt the subject’s monologue.

**Criterion B(4):** This criterion can be rated 3 based either on the subject’s subjective report that his or her thoughts are racing OR on the clinical judgment
that flight of ideas has been present (based either on observation of subject’s pattern of thinking or by history). Flight of ideas involves thoughts that are loosely connected, with the subject jumping from one topic to another very quickly, with only the slightest thread of thematic connection between topics. In some cases, the connection may be based on sound rather than meaning (clang association).

**Criterion B(5):** Distractibility refers to an inability to filter out extraneous stimuli while attempting to focus on a particular task. For example, the subject may have trouble focusing on the interviewer’s questions because of being distracted by a police siren on the street, and may need to jump up from the interview and investigate what is going on outside.

**Criterion B(6):** As a consequence of elated mood, increased energy or increased self-esteem, the person may become involved in more activities than usual. Typical “manic” activities involve calling friends at all hours of the night, writing lots of letters, beginning new creative projects. Alternatively, the increase in activity may be more diffuse and be manifest as psychomotor agitation (e.g., being unable to sit still).

**Criterion B(7):** In the pursuit of pleasure, excitement or thrills, the person may engage in activities that are uncharacteristic of them, without regard to possible negative consequences. Typical examples include lavishly spending large sums of money on luxury items, gifts for others, or expensive vacations, driving too fast, or engaging in reckless or unsafe sexual behavior. Note that the SCID question (i.e., “have you done anything that could have caused trouble for you or your family?”) is relatively non-specific in that it will pick up any behavior that reflects poor insight or judgment. This item should be coded 3 ONLY if the behavior is extremely pleasurable. For example, problematic behavior occurring in response to a command hallucination or delusion (e.g., accosting strangers with the news that doomsday is approaching) would not warrant a rating of 3.

**Criterion B (3/4 out of 7):** Note that the number of items required to meet criterion B depends on whether criterion A was coded 3 in the absence of euphoric mood (i.e., irritable mood only). If euphoric mood has been present, then only three B criteria need to be have been present. Irritable mania requires a minimum of four items to help differentiate it from irritable Major Depressive Episodes.

[DSM-IV criterion C, which excludes a diagnosis of Manic Episode if criteria are met for a mixed episode, has been omitted mixed episodes are considered in the SCID (and DSM-IV) to be a type of Manic Episode.]

**Criterion D:** A comparison of the criteria for Manic and Hypomanic Episodes reveals that these two entities share the same symptoms, but differ on the degree of severity. As indicated in this criterion, the symptoms in a Manic Episode must be sufficiently severe so as to cause marked impairment, require
hospitalization, or include psychotic features. Otherwise, a diagnosis of Hypomanic Episode should be considered (and in most cases, would be warranted). For this reason, if a rating of 1 is made, the interviewer is instructed to skip to the criteria for Current Hypomanic Episode, picking up with criterion C (since meeting criteria A and B for Manic Episode necessarily means that the corresponding criteria A and B in Hypomanic Episode are also met).

**Criterion E:** This criterion instructs the interviewer to consider and rule out a general medical condition or a substance as an etiological factor. See page 19 for a general discussion of how to apply this criterion, and pages 44 and 46 for a discussion of the criteria for Mood Disorder Due to a General Medical Condition and Substance-Induced Mood Disorder.

**Number of Episodes.** After making a rating of “3,” indicating that the criteria are met for a current Manic Episode, the interviewer is instructed to make a rough estimate about the total number of episodes in the subject’s lifetime. This entails asking the subject to report how many separate times he or she has had a Manic Episode—it does not mean that the interviewer has to inquire about each symptom for each episode. For most purposes, this estimate of the number of episodes will suffice. However, investigators interested in the specific symptom patterns characterizing each past episode may wish to turn to Module J in order to document the details of past Manic Episodes.

**Episode Specifiers:** The ratings for Current Manic Episode conclude with criteria sets for With Postpartum Onset and With Catatonic Features. If the interviewer wishes to bypass the rating of these specifiers, the interview should be continued with the next module, page B1. (Note: Dysthymic Disorder is skipped since this diagnosis is excluded by a history of a Manic Episode).

**WITH POSTPARTUM ONSET:** See page 34 in Current Major Depressive Episode.

**WITH CATATONIC FEATURES:** See page 34 in Current Major Depressive Episode.

**Ratings for Current Hypomanic Episode (A.24-A.27)**

**Criterion A:** Remember that the only way to get here in the SCID is for there to have been a 3 rating on the first part of criterion A for Manic Episode (i.e., a period of euphoric or irritable mood) that falls short of the required duration of at least one week. Therefore, in most cases the interviewer needs only to insure that the duration of the elevated or irritable mood is at least four days. Note that the second half of this criterion emphasizes that in order to rate a mood as “hypomanic,” it must be a mood state that is clearly different from the subject’s typical euthymic mood. This consideration can be most problematic in
individuals with chronic depression who may experience a return to euthymia as if it were a euphoric mood.

**Criterion B:** By definition, a Hypomanic Episode is severe enough to be distinguishable from “normal” good moods (see criteria C and D) but not so severe that it causes marked functional impairment (see criterion E). As can be seen with this criterion, the description of the specific hypomanic symptoms is identical in wording to that in the definition of a Manic Episode and is differentiated solely based on severity.

**Criterion C:** To rate this criterion 3, the interviewer must insure that mood change and other symptoms result in a clear-cut change in functioning (e.g., increased productivity at work) that is not typical of the person’s functioning when not in an episode.

**Criterion D:** To further insure that the mood change is significant, this criterion requires that the change in functioning be observable by others—a subjective sense of elevated mood that is not corroborated by others does not count. In lieu of information from informants, examples of situations in which others commented about the subject's change in behavior are acceptable.

**Criterion E:** This criterion is the opposite of criterion C in Manic Episode and requires the absence of serious consequences due to the hypomanic behavior. If serious consequences are reported, then this item should be rated 1, leaving the interviewer with one of two options. If hospitalization was necessary or a reconsideration of the duration of symptoms indicates that the episode has in fact lasted at least a week, then the interviewer should go to page A.19 and transcribe the B criterion symptom ratings from pages A.24 and A.25, make a rating of 3 for criterion D on the bottom of page A.20, and then continue with page A.21. If the episode is too severe to qualify for a diagnosis of a Hypomanic Episode and too brief to qualify for a diagnosis of a Manic Episode, then the episode is diagnosed as Bipolar Disorder NOS in Module D (i.e., Option #4 for “Other Bipolar Disorder on page D.5) unless criteria are met for a past Manic Episode, in which case the final diagnosis would be Bipolar I Disorder in Module D.

**Criterion F:** This criterion instructs the interviewer to consider and rule out a general medical condition or a substance as an etiological factor. See page 19 for a general discussion of how to apply this criterion, and pages 44 and 46 for a discussion of the criteria for Mood Disorder Due to a General Medical Condition and Substance-Induced Mood Disorder.

**Number of Episodes.** After making a rating of 3, indicating that the criteria are met for a current Hypomanic Episode, the interviewer is instructed to make a rough estimate about the total number of episodes in the subject’s lifetime. This entails asking the subject to report how many separate times he or she has had
a Hypomanic Episode—it does not mean that the interviewer has to inquire about each symptom for each episode. For most purposes, this estimate of the number of episodes will suffice. However, investigators interested in the specific symptom patterns characterizing each past episode may wish to turn to Module J in order to document the details of past Hypomanic Episodes.

Ratings for Past Manic and Hypomanic Episodes (A.28-A.37)

The issues for rating Past Manic and Hypomanic Episodes are the same as with Past Major Depressive Episodes (see page 36). Remember that if the criteria are met for a Current Manic Episode, there is no need to ask about past Manic Episodes in detail. However, if criteria are met for a Current Hypomanic Episode it is still necessary to check to see if the criteria are met for a Past Manic Episode because of the implications for the final diagnosis (i.e., a past Manic Episode would indicate a diagnosis of Bipolar I Disorder).

Ratings for Dysthymic Disorder (A.38-A.41)

Since the diagnosis of Dysthymic Disorder is not made in the presence of a chronic Psychotic Disorder, there is an instruction to skip over this section if the Overview indicates that a chronic Psychotic Disorder is likely. In rare cases it may be necessary to return to consideration of Dysthymic Disorder if it later becomes apparent that there is no chronic Psychotic Disorder.

In the SCID (unlike in DSM-IV) the diagnosis of Dysthymic Disorder is made only if it is current (i.e., criteria met for at least the past two years) because of the difficulty in making a reliable retrospective assessment. In the absence of any current or prior Major Depressive Episodes, the assessment of Dysthymic Disorder is straightforward (i.e., has there been depressed mood, plus additional depressive symptoms, for more days than not, for the past two years?) However, when there is a current or past Major Depressive Episode, making an additional diagnosis of Dysthymic Disorder is more complicated, since it is important in such cases to distinguish between Dysthymic Disorder with superimposed Major Depressive Disorder (so-called “double depression”) and partially remitted Major Depressive Disorder. This differential diagnosis depends on whether the two-year period of chronic mild depression preceded the Major Depressive Episode (in which case both diagnoses would be appropriate) or whether the chronic depressed mood comes only after the Major Depressive Episodes (in which case only a diagnosis of Major Depressive Disorder In Partial Remission would apply). Figures 1-5 (page 42a) graphically illustrates this differential. Figure 1 shows recurrent Major Depressive Disorder (with full interepisode recovery), and figure 2 depicts Dysthymic Disorder (without any superimposed Major Depressive Episodes). Figure 3 illustrates Major Depressive Disorder In Partial Remission in which the Major Depressive
Figure 1: Major Depressive Disorder, Recurrent

Figure 2: Dysthymic Disorder

Figure 3: Major Depressive Disorder in Partial Remission

Figure 4: Dysthymic Disorder Superimposed on Major Depressive Disorder

Figure 5: Dysthymic Disorder With Prior Major Depressive Disorder
Episode tapers off into a chronically depressed but less severe mood disturbance. The bottom two drawings illustrate two cases in which it is appropriate to diagnose both Major Depressive Disorder and Dysthymic Disorder. The first (figure 4) shows a 2-year-plus period of Dysthymic Disorder with a Major Depressive Episode superimposed later in the course. Figure 5 shows a 2-year-plus period of Dysthymic Disorder following a Major Depressive Episode but, in contrast to figure 3 (which shows Major Depression In Partial Remission), there is a 2-month-plus period of remission between the Major Depressive Episode and the Dysthymic Disorder.

It is not always easy to distinguish a pattern of “double depression” from frequently recurring depressive episodes separated by periods of partial remission of the Major Depression, and for many studies this may be an unnecessary distinction. If an investigator is interested only in differentiating chronic depression from recurrent, remitting depression, or in differentiating any depression from no depression, attempts to assess for “double depression” may not justify the time and effort required. In such cases, investigators may wish to insert an instruction at the beginning of the Dysthymic Disorder section to skip the section under certain circumstances (e.g., if there have been recurrent Major Depressive Episodes, if Major Depressive Disorder has been present in the past year, etc.)

**Criterion A:** The choice of which initial probe question is most appropriate depends on whether or not there has been a Major Depressive Episode in the past two years. If there has been, the time frame to inquire about a 2-year period of depressed mood is shifted to precede the Major Depressive Episode. Three options are offered: 1) in the absence of any Major Depressive Episodes in the past two years, the interviewer just asks if the subject has been depressed for more than 50% of the past two years; 2) if a Major Depressive Episode is present, the interviewer must first determine the approximate date that the Major Depressive Episode started, and then ask about the two years just prior to the onset of that Major Depressive Episode; 3) if there has been just one Major Depressive Episode in the past two years (but the subject is not currently in a Major Depressive Episode), the interviewer begins by determining the approximate dates that the Major Depressive Episode started and ended, and then asks about the two years just prior to the onset of that Major Depressive Episode, as well as inquiring about the period of time since the end of that Major Depressive Episode to see whether the dysthymic symptoms persisted. When assessing this item, it is often helpful for the interviewer to draw a figure (like those in figures 1-5) indicating the longitudinal course of the depression.

**Criterion B:** Items 1, 2, 3, and 5 are identical to the corresponding items for Major Depressive Episode, except that they need not occur nearly every day for at least two weeks. All of the symptoms may be intermittent, but must be present more than half of the days in the two-year period under consideration. Item 4 is set at a lower threshold, in that it requires only low-self esteem, and not a feeling of worthlessness or inappropriate guilt.
**Criterion C:** In order to insure the chronic nature of Dysthymic Disorder and to differentiate Dysthymic Disorder from recurrent minor depression, the interviewer must make sure that the subject never had any significant (i.e., more than two months) depression-free periods.

**Criterion D:** As discussed above, whether a chronic depressed mood represents Dysthymic Disorder or Major Depressive Disorder in Partial Remission depends on the severity of the symptoms and the initial onset of the depression. If the disorder begins with a two-year period of depression that is less severe than a Major Depressive Episode, the diagnosis of Dysthymic Disorder is appropriate. If no such two-year period can be documented, the depression is better accounted for by a diagnosis Major Depressive Disorder in Partial Remission with a prolonged depressive prodrome.

**Criterion E:** Dysthymic Disorder is “unipolar” --there can never have been any Manic or Hypomanic Episodes.

**Mood Disorder Due to a General Medical Condition/Substance-Induced Mood Disorder (Secondary Mood Disorder) (A.43-A.46)**

This section of the SCID is consulted only in the course of evaluating the “organic rule out” criterion that is included in the criteria sets for Major Depressive Episode, Manic Episode, Hypomanic Episode, Dysthymic Disorder, Bipolar Disorder NOS, and Depressive Disorder NOS. The SCID rule is that if there is any indication that a drug of abuse, medication, or general medical condition may be responsible for the mood disturbance through a direct physiological mechanism, the interviewer should jump to this section to make a more definitive judgment. This section starts with a skip instruction that directs the interviewer to consider Mood Disorder Due to a GMC if a general medical condition is suspected to be causally involved and/or to Substance-Induced Mood Disorder if a substance may be responsible.

**Due to a General Medical Condition:** When a general medical condition and mood disturbance co-occur, it can be challenging to elucidate the particular nature of their relationship. Four such relationships are possible: 1) the mood disturbance may be caused by the direct physiological effects of the general medical condition on the central nervous system (e.g., brain tumor or hypothyroidism causing depression); 2) the mood disturbance may be a psychological reaction to having the general medical condition (e.g., depression in response to the physical disability caused by a stroke); 3) the mood disturbance may be caused by the direct physiological effects of a medication used to treat the general medical condition; and 4) the two may be co- incidental. The interviewer’s task here is to distinguish the first relationship (which would
lead to a diagnosis of Mood Disorder Due to a General Medical Condition) from the other three.

**Criterion A:** The criterion is included for completeness and is essentially automatically coded 3 (i.e., you would be here only if there were depressed, elevated, or irritable mood that you suspect is due to a GMC).

**Criterion B/C:** In the SCID, these two DSM-IV criteria have been combined into a single item since they are essentially flip sides of the same concept. Rating this criterion entails the often difficult (and sometimes impossible to make) judgment that the general medical condition is etiologically responsible for the mood disturbance. Please note that whereas depression is commonly comorbid with a general medical condition, Mood Disorder Due to a General Medical Condition is relatively rare. Therefore, when in doubt, the interviewer’s default position should be to assume that the medical condition is NOT etiological (i.e., the mood disorder is primary). Although DSM-IV does not provide specific criteria for making this determination, the SCID includes four guidelines derived from the DSM-IV text that may be helpful:

1) **Is it reasonably well-established in the medical literature that mood disturbance is an associated feature of the general medical condition?** For example, hypothyroidism is a well-documented cause of depression whereas gastric ulcer is not.

2) **Is there a close temporal relationship between the course of the mood symptoms and the course of the general medical condition?** Do the mood symptoms start following the onset of the general medical condition, get better or worsen with the waxing and waning of the general medical condition, and remit when the general medical condition is resolved? The questions provided in the left-hand column of the SCID address these relationships. When all of these relationships can be demonstrated, one can make a fairly compelling case that there is a causal connection between the mood symptoms and the GMC. It is important to note that demonstration of a close temporal relationship does not necessarily imply that the causality is on a physiological level—a psychological reaction would likely have a close temporal relationship as well. Furthermore, the lack of a temporal relationship does not necessarily rule out causality. In some instances, mood symptoms may be the first harbinger of the general medical condition and may precede by months or years any physical manifestations (e.g., brain tumor). Conversely, mood symptoms may be a relatively late manifestation, occurring months or years following the onset of the general medical condition.

3) **Are the mood symptoms characterized by atypical presenting features (e.g., late age at onset)?** For example, severe weight loss in the face of a relatively mild depression, or the first onset of mania in an elderly patient increases the likelihood that a general medical condition is responsible. It should be realized,
however, that atypicality is not necessarily compelling evidence since by their very nature, psychiatric presentations are quite heterogeneous within a particular diagnosis.

4) **Are there no reasonable alternative explanations?** Has the patient had prior episodes of mood disturbance not due to a GMC? Is the patient abusing substances that can cause mood disturbance or taking a medication that might cause a mood disturbance? Does the patient have a strong family history for mood disorders?

Since each of these guidelines is potentially fallible, they should all be considered and, ultimately, the final judgment is a clinical call. Because of the inherent difficulty in making this judgment, we recommend that investigators in a particular study establish a “policy” with respect to the threshold of evidence required to justify a decision that the general medical condition is etiological. As discussed above, Mood Disorder Due to a General Medical Condition is relatively rare so that, for most studies, it probably makes sense to maintain a high threshold (i.e., when in doubt, do not diagnose Mood Disorder Due to a General Medical Condition). However, in those studies in which it is particularly important to screen out possible etiological general medical conditions, it may make sense to establish a very low threshold (i.e., any possible associated general medical condition would result in the individual being screened out).

**Criterion E:** Clinical Significance criterion (see page 33).

**Criterion D:** Although the SCID does not provide the specific criteria for delirium, it includes the criterion enforcing the hierarchical relationship between delirium and other mental disorders due to a general medical condition. The hallmark of delirium is an inability to maintain or change attention appropriately, typically evidenced by the subject being unable to follow along with your questions during the SCID.

**Substance-Induced:** This section begins with a skip-out instruction that tells you to “return to the episode being evaluated” if there is no temporal association between the mood symptoms and a substance, an instruction that repeats itself throughout pages A.45 and A.46. Recall that you are rating these items only in the course of evaluating a criterion in the form of “not due to the direct ...effects of a substance or GMC.” Therefore, when you conclude this section, you must resume the interview by making a rating for that item and continuing on. The box on the upper right hand side of page A.45 provides guidance as to where in the SCID you should return.

When substance use and mood symptoms co-occur, there are three possibilities as to the nature of their relationship to each other: 1) the mood symptoms may be a direct physiological consequence of the substance use (e.g., Cocaine-Induced Mood Disorder, With Depressive Features, With Onset During Withdrawal); 2) the substance use may be a feature of the mood disorder (e.g., cocaine use to self-medicate an underlying depressive disorder);
and 3) the two may be coincidental. The ratings for Substance-Induced Mood Disorder involve separating the first causal connection from the other two. It should be recalled that in DSM-IV, the term “substance use” includes the use of prescribed medication, as well as somatic therapies such as electroconvulsive treatment and phototherapy.

**Criterion A:** This criterion is included for completeness and is essentially automatically coded 3 (i.e., you would be here only if there is depressed, elevated, or irritable mood that you suspect is due to a substance).

**Criterion B:** This criterion establishes a temporal relationship between substance use and the development of the mood symptoms. Part (1) of this criterion applies to drugs of abuse whereas Part (2) applies to medication use. For drugs of abuse, this criterion establishes that the mood symptoms occur in the context of Intoxication or Withdrawal, thereby implying that enough of the substance was used to have caused intoxication or withdrawal.

**Criterion C:** Given that there is a temporal relationship between the onset of the mood symptoms and substance use (as per criterion B), this criterion allows you to make an etiological connection between the substance and the mood symptoms so long as there is no other non-substance-related explanation that better accounts for the mood symptoms. Four suggested guidelines are presented:

1) *Does the substance use clearly follow the onset of the mood symptoms?* If so, the mood clearly cannot be caused by the substance use and instead the “self-medication” model would seem to apply.

2) *Do the mood symptoms persist, even after a substantial period of abstinence (e.g., a month)?* If the mood symptoms were caused by the substance use, then one would expect that they would remit after the acute effects of intoxication and withdrawal subside. If the mood symptoms continue to persist long after the substance use ends, it suggests instead that the mood symptoms represent a primary mood disorder (or perhaps a Mood Disorder due to a General Medical Condition). Note that the one-month period is provided only as a loose guideline. The actual amount of time of abstinence that would be required before concluding that the mood symptoms are primary depends on many factors such as the particular substance used and dosage.

3) *Are the mood symptoms much more severe than one would expect given the nature and amount of the substance used?* If so, then it would not make sense to attribute the mood symptoms to the substance (e.g., severe depression following a small amount of cocaine use suggests Major Depressive Disorder rather than Cocaine-Induced Mood Disorder).
4) Is there any other evidence that is more supportive of a primary Mood Disorder or a Mood Disorder Due to a General Medical Condition? The interviewer should take into account such factors as a strong family history for primary Mood Disorder, prior episodes of Mood Disorder that were not related to substance use, and evidence for an etiological general medical condition.

Note that these are only examples of scenarios that suggest a non-substance-related explanation and do not conclusively rule out a substance-induced disorder. Clinical judgment must be applied.

Criterion E: Clinical Significance criterion (see page 33).

Criterion D: See page 46.

10.4 MODULE B. PSYCHOTIC AND ASSOCIATED SYMPTOMS

This module is for rating the lifetime occurrence of psychotic and other symptoms (e.g., delusions, hallucinations, disorganized speech and behavior, and negative symptoms) included in the criteria sets for the Psychotic Disorders. Ratings for the specific criteria are contained in Module C (i.e., ratings for Schizophrenia, Schizotypal Personality Disorder, Schizoaffective, and Brief Psychotic Disorder, Psychotic Disorder Due to a General Medical Condition, and Substance-Induced Psychotic Disorder) and Module D (i.e., ratings for Bipolar I Disorder With Psychotic Features and Major Depressive Disorder With Psychotic Features). Because the interviewer is assessing lifetime psychotic symptoms it is necessary to date occurrences of specific symptoms. If a subject is too psychotic or disorganized to sit through a SCID interview, the evidence for psychotic symptoms will come from medical records or informants. In such situations, the SCID can be used as a place to document symptoms and to apply the diagnostic algorithms in the C module rather than as a structured interview.

Interviewing for Psychotic Symptoms: In most subjects with a Psychotic Disorder, the presence of a psychotic symptom has been established earlier in the interview (usually in the Overview). In such instances, the B module may serve more as a checklist for rating psychotic symptoms rather than an interview guide. In fact, this is the one part of the SCID where the rule requiring the interviewer to paraphrase a question into a confirmatory question if the answer is already known does not apply. For example, if the interviewer has already established during the Overview that the subject believes that he is God, there is no need to say, “you’ve told me that you are especially important in some way or that you have the power to do things that other people couldn’t do.” It is still important to ask all subjects (even those who have reported some psychotic symptoms) those questions about psychotic symptoms that have not yet been reported since they are useful both as a general screen for psychotic symptoms
and to determine the full range of psychotic symptoms in individuals with a psychotic disorder.

**Rating delusions:** A delusion is a false personal belief based on incorrect inference about external reality that is firmly sustained despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary. The belief is not one ordinarily accepted by other members of the person's culture or subculture (e.g., the belief in some cultures that one can communicate with a dead person). When the interviewer is unfamiliar with the beliefs characteristic of the individual's cultural or religious background, consultation with someone else who is familiar with the subject's culture may be required to avoid the overdiagnosis of delusions.

A delusion involves impairment in the ability to make logical inferences--the way conclusions are drawn from observation of the person's environment or self (e.g., phone hang-ups indicate that the person is being spied on). In rating each type of delusion, the interviewer must differentiate a delusion (which would warrant a rating of 3) from a strongly held "overvalued" idea (which would warrant a rating of 2). In deciding whether a belief is false and fixed enough to be considered a delusion, the interviewer must first determine that a serious error in inference and reality testing has occurred and then determine the strength of the conviction. It may be helpful to ask the subject to talk at length about his conviction because it is often only in the specific details that the errors of inference become apparent. In evaluating the strength of the delusional conviction, the interviewer should present alternative explanations (e.g., is it possible that the phone hang-ups are due to people dialing a wrong number?).

A delusional subject may acknowledge the possibility of these explanations, but will still hold firm to his or her own belief. Some subjects with a longstanding history of psychotic disorder have developed insight into the "psychotic" nature of their delusions. Such a symptom would still be considered "psychotic" as long as, at some earlier point, the symptom was experienced as real. For example, a subject may report that his chronic conviction that people at work are plotting against him is a result of his longstanding Schizophrenia. This would be coded as a delusion if either the subject reports that initially he was convinced the plot was real or if there is such evidence from prior records (e.g., an admission note documenting that he acted on his belief).

The next set of ratings documents the type of delusion, based on content. Note that for a particular delusion, more than one rating may apply. For example, a subject who believes that the FBI is after him because he can control other people's minds would have both persecutory and grandiose types of delusions coded 3.

**Delusion of reference:** This question has a relatively high false positive rate. The interviewer should therefore ask for specific examples that establish the psychotic nature of the belief. Most people have at sometime felt that other people were talking about them, particularly if they have some obvious physical abnormality or act in a way that makes them stand out. It is therefore important
to differentiate realistic perceptions, social anxiety or transient suspiciousness from a fixed false belief. A homeless man who dresses in rags and has no place to take a shower may realistically believe that people are moving away from him on the subway, but if he believes that today’s headlines are a cryptic reference to his personal life, the interviewer should rate this item a 3.

**Persecutory delusion:** The interviewer should take care to differentiate an exaggerated, but possibly valid, perception of persecution (e.g., by a boss, a teacher, an ex-spouse, a drug dealer) from a real persecutory delusion. There may be cases in which it is impossible to know whether the persecution is real or delusional. These should be coded ?.

**Grandiose delusion:** It is sometimes hard to tell where an inflated perception of one’s talents ends and a grandiose delusion begins. A taxi driver who believes he will write a best selling novel may be mistaken, but not necessarily delusional. If, however, he tells the interviewer that Steven Spielberg has been calling, begging for the movie rights to his novel, he has probably stepped over the line into delusion. Questioning him about his evidence for the belief is a good way to clarify the issue.

**Somatic delusion:** In assessing this symptom, it is necessary to take into account the subject’s understanding of anatomy and physiology. An uneducated person may have a primitive explanation of symptoms, for example, believing that stomach pains are caused by a grasshopper hopping around inside him. His willingness to entertain an alternative explanation indicates that the belief is not a delusion. Another example of a false positive would be a patient with physical symptoms who doubts an internist’s reassurance that she has no medical illness. If the patient is able to entertain the possibility that her beliefs are exaggerated, then the diagnosis would be Hypochondriasis. A patient who dismisses such reassurances out of hand is more likely to have a somatic delusion.

**Other delusions:** Other types of delusions that do not easily fit into one of the specified types are coded here.

**Delusions of control:** Inexperienced interviewers sometimes incorrectly code delusions of control, thought broadcasting, thought withdrawal, etc. as present. The essential feature of these bizarre delusions is that the subject experiences the process as being under the control of an outside force. For example, when asked about delusions of control, a subject may respond that her mother is always trying to control her. It is up to the interviewer then to determine whether she is talking about her actions or thoughts being controlled in some mysterious way (a true delusion of control) or whether she is simply describing a chronic struggle with her mother about what she is and is not allowed to do (probably not a delusion of any kind.)
Thought broadcasting: This rare delusion entails the experience that others can hear the subject’s thoughts because they are being broadcast out loud. The subject often also hears the broadcast thoughts as a hallucination (which should be coded “3” on the next page). A much more common phenomenon is the experience that others can read one’s mind. That should be coded as a bizarre delusion, but not as thought broadcasting.

Bizarre delusion: It is important to differentiate between a delusion that is truly "bizarre," i.e., involving a phenomenon that the person's culture would regard as totally implausible, and one that is simply unlikely. An example of a non-bizarre delusion is the belief that one is being followed by the FBI. On the other hand, the belief that the FBI has implanted a computer chip in one’s brain and is controlling all of one's actions would be considered bizarre.

Auditory Hallucinations: Auditory hallucinations should be differentiated from delusions of reference, in which the subject hears actual voices (on the street, on the ward, etc.) and interprets them self-referentially. Evidence that they are, in fact, hallucinations might be that they occur when the subject is alone. This item should be coded 3 only if the hallucinations are judged to be clinically significant, i.e., recurrent or persistent. Hearing one’s name being called and finding no one there is an example of a hallucination that is not clinically significant. A hallucination (the experience of sensory perception without stimulation of the relevant sensory organ) should also be distinguished from an illusion, which is a misperception of an actual stimulus (e.g., misinterpreting a shadow as the figure of a man).

Disorganized Speech: This item is usually assessed by history and almost always requires another informant. If the subject’s speech is disorganized enough to warrant a rating of 3, it may be difficult or impossible to administer the SCID.

The assessment of this criterion requires a subjective judgment by the interviewer as to the “understandability” of the subject’s speech. The most common error is to have too low a threshold for disorganization, leading to an overdiagnosis of Schizophrenia. It is unwise to assume that every subtle illogical shift from one topic to another necessarily has pathological significance. Latitude should be given to account for variations in style, particularly in the stressful situation of a psychiatric interview. Only speech that is severely disorganized and very difficult to interpret should be considered for a rating of 3. A final caution is that the interviewer’s unfamiliarity with the subject’s dialect or accent or the subject’s lack of proficiency in the interviewer’s language should not be misdiagnosed as disorganized speech.

Disorganized Behavior: Two judgments are required here— that the behavior is “disorganized” and that it is severe ("grossly"). Disorganized behavior does not have any apparent goal. Examples of disorganized behavior include wandering around aimlessly and unpredictably shouting at passersby. It is important to
exclude behavior that may appear disorganized or bizarre but in fact has a goal (e.g., collecting worthless items from trash dumpsters in response to a delusion that they would provide protection against radiation). In order to justify a rating of 3, the disorganization must be severely impairing and obvious even to the most casual observer.

**Negative symptoms:** The main problem with the diagnosis of negative symptoms is overdiagnosis. Like disorganized speech and grossly disorganized behavior, there is a continuum of severity for each of the negative symptoms and only the most severe, pervasive, persistent, and impairing forms should warrant a rating of 3 for this item. For example, the range of affective expression varies widely in the population and among different cultural groups. Many people are laconic without having negative symptoms. The lack of goal direction meant to be conveyed by the term “avolition” is at the extreme end of a spectrum and should not be confused with lesser and more common difficulties in getting started.

Furthermore, it is important to insure that other explanations for the behavior be considered and ruled out before rating this item a 3. The most common confusion in this regard is probably due to the fact that the very medications used to treat psychotic disorders can produce side effects that appear to be negative symptoms. For example, many patients on antipsychotic medication experience loss of facial expressiveness, reduced speech and movements, dysphoria, and loss of energy. It may be useful to inquire whether negative symptoms were present prior to the onset of the neuroleptic treatment, and a reduction or change in medication or the addition of an anticholinergic agent may sometimes be informative. It can also be difficult to distinguish between negative symptoms (affective flattening, alogia, and avolition) and depressive symptoms (constricted affect, psychomotor retardation, indecisiveness, loss of energy, and loss of pleasure) that not infrequently accompany psychotic disorders. Finally, negative symptoms must be differentiated from behaviors that are secondary to positive symptoms. For example, a subject experiencing a command hallucination to remain perfectly silent would not also be considered to have the negative symptom alogia. Similarly, a subject who is unable to maintain a job because of persecutory delusions would not also be counted as having avolition.

In order to emphasize the importance of not overdiagnosing negative symptoms, the interviewer is required to rate each negative symptom twice—the initial rating indicates the apparent presence of the symptom and the second rating confirms that the symptom is in fact “primary” (i.e., a negative symptom of Schizophrenia) rather than “secondary” (e.g., a side effect of medication, a depressive symptom, or the consequence of a positive symptom). (NOTE: the terms “primary” and “secondary” have different meanings here than when used in the context of ruling out a general medical condition and substance as the cause of psychopathology).
B/C. PSYCHOTIC SCREENING

This module replaces the Psychotic and Associated Symptoms and Psychotic Disorders modules in the SCID-P (W/PSYCHOTIC SCREEN) and SCID-NP. Its purpose is to determine whether a psychotic symptom has been present at any time, but it does not include enough detail to make a complete differential diagnosis. In many studies in which this module is used, any evidence of psychotic symptomatology will eliminate the subject from the study. For studies that include subjects with a psychotic Mood Disorder but screen out other psychotic disorders, the B/C module allows the interviewer to make this judgment.

10.5 MODULE C. PSYCHOTIC DISORDERS

This module allows the interviewer to make a differential diagnosis of Psychotic Disorders based on information obtained in the A and B modules. The Psychotic Disorders module is skipped over if there has never been a psychotic symptom, or if the psychotic symptoms occur only during mood episodes.

This module is different from Modules A and B in several ways. Whereas the primary goal in modules A and B is to collect specific information from the subject (and/or other informants) about the clinical presentation in order to determine whether individual criteria are met, the goal in module C is to determine which psychotic disorder best accounts for the particular symptomatic presentation. Proceeding through module C is akin to moving down the DSM-IV decision tree for psychotic symptoms. The main focus of the interviewer’s efforts is on the consideration of whether the criterion in the center column is present or absent--note the absence of 2 ratings--only ?, 1, or 3 are permitted. Because many of the items are complicated and involve double negatives, notes written in all capital letters are provided below many of the criterion items as a quick guide to what the ratings mean. It is suggested that the interviewer review the notes before making the final rating to confirm that the criterion item has been correctly interpreted.

For most items in Module C, there is no need to ask a question, although for some items, additional clarification may be required. In many cases the last thing said to the subject (until Module E) is the phrase “Let us stop for a moment while I make a few notes” on page B.5. The interviewer then proceeds to rate the criteria and flip through pages while the subject looks on. We therefore recommend that the interviewer become proficient in using this section so it can be done quickly and the subject is not waiting while the interviewer ponders each word in Module C. (We recommend using the case vignettes in Appendix B for practice!) Do NOT skip over this module with the idea that it can be completed at a later time, since additional questions may be required.
Note that there are two situations in which the interviewer may have to go back to the A module to recode items: 1) If the diagnosis of Dysthymic Disorder was made in the A module and then a psychotic disorder diagnosis is made in the C module, then the rating for criterion F in Dysthymic Disorder (i.e., "does not occur exclusively during a chronic Psychotic Disorder") may have to be recoded; OR 2) Because of the difficulty in distinguishing the negative symptoms of Schizophrenia from symptoms of depression, a Major Depressive Episode that has been previously diagnosed in the A module might have to be recoded if a diagnosis of Schizophrenia is made in the C module. In these cases, the interviewer should return to the A module and recode any equivocal items as 1 if they are determined to be negative symptoms of Schizophrenia.

Recurrent Psychotic Episodes: Some psychotic disorders tend to be chronic (i.e., Schizophrenia, Delusional Disorder) whereas others tend to be more episodic (Mood Disorder With Psychotic Features, Schizoaffective Disorder). Although most individuals with recurrent psychotic episodes have recurrences that are characterized by similar symptom presentations, there are rare cases in which the presentation markedly changes from episode to episode, so that, for example, one episode may meet criteria for a Bipolar Disorder with Psychotic Features (e.g., delusions confined to a Manic Episode) while another episode meets the criteria for Schizoaffective Disorder (delusions persist for two weeks after the Manic Episode has resolved). In such circumstances, we recommend that each episode be given its own diagnosis as a way of communicating the most information--an admittedly suboptimal solution, since such individuals probably do NOT have more than one disorder.

R/O Psychotic Mood Disorder (C.1)

The hallmark of a Mood Disorder With Psychotic Features is that psychotic symptoms occur only during Mood Episodes. This initial criterion (which is not actually part of the criteria set for any DSM-IV disorder) has been included in the SCID to allow the interviewer to skip past the evaluation of non-mood psychotic disorders.

Ratings for Schizophrenia (C.2-C.10)

Note that the criteria for Schizophrenia are presented in the SCID in a different order than in DSM-IV for the purpose of maximizing diagnostic efficiency (e.g., the user immediately skips out of Schizophrenia if the temporal relationship between mood and psychotic symptoms indicates Schizoaffective Disorder or a psychotic Mood Disorder).

Criterion A: This criterion defines the “active phase” of Schizophrenia, which is required at some point during the individual’s lifetime in order for a diagnosis of
Schizophrenia to be warranted. Note that in some cases the active phase symptoms may have been present many years before the interview. This criterion requires that there be an active phase lasting at least one month (or "less if successfully treated.") This latter phrase acknowledges that clinical judgment is required when applying the duration criterion. In an individual who has been promptly and aggressively treated with antipsychotic medication, if the other aspects of the illness are unequivocally present, it does not make sense to require a full month's duration.

**Criterion D:** For presentations characterized by a mixture of mood and psychotic symptoms that meet criterion A for Schizophrenia, the differential diagnosis includes Schizophrenia, Schizoaffective Disorder, and Mood Disorder With Psychotic Features. As discussed above, the interviewer has already been instructed to skip out of Module C if the diagnosis is Mood Disorder With Psychotic Features. This criterion delineates the admittedly inexact boundary between Schizophrenia and Schizoaffective Disorder. A 3 rating indicates that Schizoaffective Disorder has been ruled out and the interviewer is instructed to continue with criterion C on page C.4. A 1 rating indicates that a diagnosis of Schizoaffective Disorder is likely and that the interview should resume on page C.13.

The two essential aspects of the boundary between Schizophrenia and Schizoaffective Disorder are embodied in the two different parts of criterion D. The first part operationalizes the requirement in Schizoaffective Disorder that mood episodes occur concurrently with the active phase symptoms of Schizophrenia (corresponding to criterion A in Schizoaffective Disorder). If this is not the case, then Schizoaffective Disorder is ruled out on this ground alone and the interviewer can continue with Schizophrenia criterion C. Note that the first part of criterion D is a double negative—we recommend that you follow the instructions laid out in the note below the criterion in order to prevent a wrong turn here! If there is a mood episode occurring concurrently with the psychotic symptoms (suggesting the possibility of Schizoaffective Disorder), the interviewer must then evaluate the second half of the criterion to determine the relationship between the duration of the mood symptoms and the duration of the total disturbance. If the total duration of the mood episodes are BRIEF relative to the total duration of the disturbance (including residual and active phases), then this criterion should be rated 3 and the interviewer should continue with the assessment of the remaining criteria for Schizophrenia. If, on the other hand, the mood episodes are NOT brief (i.e., the mood episodes are a significant part of the total picture), then the criterion is rated 1 and the interviewer proceeds with the criteria for Schizoaffective Disorder on page C.13. Unfortunately, to the distress of most SCIDDERS, neither DSM-IV (nor this User's Guide) provides a precise definition of "brief" vs. "significant." This is a clinical judgment that is certainly one of the sources of unreliability in this diagnosis.

Even if DSM-IV offered a precise definition of the term "brief," this would still be a difficult criterion to assess reliably since most subjects (as well as hospital records) are not very good at being able to accurately recount the
relative persistence of mood episodes vs. psychotic symptoms. At one end of
the spectrum is the forty year old patient who was depressed and suicidal for a
few months when he had his first psychotic episode at 20, but has gone on to a
20 year course of waxing and waning psychotic symptoms, without additional
mood episodes. In this situation, the mood episode was clearly “brief” relative to
the duration of the psychotic symptoms, ruling out a diagnosis of Schizoaffective
Disorder (i.e., criterion D[2] is rated 3). At the other end of the spectrum is the
subject becomes severely depressed for months every time there has been an
exacerbation of his psychotic symptoms. In this case, since the total duration of
mood episodes is clearly not brief relative to the total duration of the disturbance,
the interviewer gives a rating of 1 to criterion D(2) and continues on page C.13
with the assessment for Schizoaffective Disorder. Unfortunately, most subjects
fall somewhere in the middle of this continuum. Some researchers have
operationalized the cutoff for “brief” as less than 10-20% of the total disturbance.
For those interviewers using the SCID in a study in which a reliable diagnosis of
Schizoaffective Disorder is particularly important, we recommend that a specific
cut-off duration be explicitly established among all the interviewers conducting
SCIDs. It should be noted that this criterion is one of the few in the SCID in
which the ? rating has its own skip instruction (i.e., directing the interviewer make
a diagnosis of Psychotic Disorder NOS). This provision acknowledges that in
those situations in which the interviewer is unable to determine the overlap or
relative duration of mood and psychotic symptoms, a diagnosis of Psychotic
Disorder NOS (and Depressive Disorder NOS or Bipolar Disorder NOS in
Module D) is probably the most appropriate choice.

**Criterion C:** The six-month duration criterion, which differentiates between
Schizophrenia and Schizophrreniform Disorder, is generally only an issue in first
break patients. Note that the six-month duration includes any combination of
active, prodromal and residual symptoms. A subject is considered to be in the
prodromal or residual phase of Schizophrenia if there are considerable negative
symptoms equivalent to those present during the active phase (see criteria A(5)).
Alternatively, the subject can be considered to be in the prodromal or residual
phase if there are milder versions of the symptoms listed in A(1)-A(4) above. For
example, before becoming frankly delusional or after recovering from delusions,
the subject may have overvalued ideas, ideas of reference, or magical thinking
with content similar to what, in the active phase, is a delusional conviction.
Similarly, the subject who experiences hallucinations during the active phase
may have unusual perceptual experiences in the prodromal or residual phases
(e.g., recurrent illusions, perceptions of auras, sensing a force). Disorganized
speech that is incoherent during the active phase may be digressive, vague, or
overelaborate in the prodromal or residual phases. The person may continue to
act in a peculiar fashion but no longer exhibit grossly disorganized behavior.

**Criterion B:** Functional impairment resulting from the above symptoms is usually
quite evident from the Overview, so this is a question that you will usually not
need to ask.
**Criterion E:** This criterion instructs the interviewer to consider and rule out a general medical condition or a substance as an etiological factor. See page 19 for a general discussion of how to apply this criterion and pages 44 and 46 for a discussion of the criteria for a Mood Disorder Due to a General Medical Condition and a Substance-Induced Mood Disorder which also apply to Psychotic Disorder Due to a General Medical Condition or a Substance-Induced Psychotic Disorder. Note that the presence of certain psychotic symptoms (e.g., hallucinations in modalities other than auditory) or an atypical course (e.g., first onset of psychotic symptoms after age 60) strongly suggests the possibility of a general medical or substance etiology.

If the patient has had a primary psychotic disorder but also has psychotic symptoms due to a GMC/Substance, both can be diagnosed by going through Module C more than once (i.e., one time for the primary psychotic symptoms and a second time for the “organic psychosis”). For this reason there is an instruction in the box under the 1 code to go back to page C.1 and start the decision tree again after making a diagnosis of GMC/Substance-Induced Psychotic Disorder if there is evidence that the subject has also had psychotic symptoms at other times (i.e., when not using substances or suffering from a general medical condition).

**Schizophrenia Subtypes:** Once a diagnosis of Schizophrenia is made, the interviewer is instructed to determine which subtype is relevant to describe the current clinical state. Researchers who are not interested in this level of symptomatic detail may choose to skip directly to the SCHIZOPHRENIA CHRONOLOGY section, page C.8. (Note, however, that the diagnostic code for Schizophrenia requires a determination of the particular subtype.)

**Schizophrenia Chronology:** Besides the standard Chronology sections (see page 22), the Schizophrenia Chronology includes the DSM-IV course specifiers that describe the general course of the illness. Note that these specifiers can only be applied to cases in which at least a year has elapsed since the onset of the active phase.

**Ratings for Schizophreniform Disorder (C.11-C.12)**

The SCID resumes at this point if criteria A and D of Schizophrenia are present (i.e., active phase symptoms for at least a month, and Schizoaffective Disorder has been ruled out) but criterion C is not true (i.e., total duration is NOT greater than six months).

**Criterion A:** This criterion has already been assessed for Schizophrenia.

**Criterion B:** It is important to insure that the psychotic symptoms have lasted at least one month, since it is possible to be at this point in the SCID with a period
of psychotic symptoms that have lasted for less than one month (e.g., delusions and hallucinations that remitted after two weeks due to successful treatment with neuroleptics). For psychotic symptoms lasting less than one month, a diagnosis of Brief Psychotic Disorder is made.

**Criterion C:** This criterion instructs the interviewer to consider and rule out a general medical condition or a substance as an etiological factor. See page 19 for a general discussion of how to apply this criterion, and pages 44 and 46 for a discussion of the criteria for a Mood Disorder Due to a General Medical Condition and a Substance-Induced Mood Disorder, which also apply to Psychotic Disorder Due to a General Medical Condition and Substance-Induced Psychotic Disorder.

**Provisional:** Once a diagnosis of Schizophreniform Disorder is made, the interviewer is instructed to indicate whether the diagnosis is “provisional” or “definite.” Strictly speaking, the diagnosis of Schizophreniform Disorder requires that the subject recover within 6 months. If the diagnosis is made in an individual who has not yet recovered (e.g., an individual with the onset of symptoms four months ago), “provisional” is indicated by a rating of 2.

**Ratings for Schizoaffective Disorder (C.13-C.14)**

The SCID picks up at this point if criterion A for Schizophrenia is rated 3 (i.e., active phase symptoms for at least a month) and both criterion D(1) and D(2) for Schizophrenia are rated 1 (i.e., there is a period of overlap between Mood Episodes and psychotic symptoms AND the total duration of the mood episodes is not brief relative to the total duration of the disturbance).

**Criterion A.** Although no minimum duration is explicitly noted in this criterion, it is assumed that the minimum duration of a Major Depressive Episode, Manic Episode, or Mixed Episode applies. Therefore the minimum duration for the overlapping period of mood and psychotic symptoms would be two weeks for a Major Depressive Episode or one week for a Manic Episode. Actual durations of mood episodes in Schizoaffective Disorder are usually much longer, comprising months or even years.

It can be a clinical challenge to sort out the degree to which a particular symptom is attributable to the mood episode, criterion A of Schizophrenia (see page 54), a medication side effect, or some combination of the three. For example, it can be very difficult to distinguish depressive symptoms from negative symptoms or antipsychotic medication side effects, or to determine whether disorganized excited behavior is part of criterion A of Schizophrenia or characteristic of a Manic Episode. For this reason, Major Depressive Episodes occurring as part of Schizoaffective Disorder must, by definition, be characterized by the presence of depressed mood and not only by
its alternative symptom, decreased interest or pleasure in activities (which can be indistinguishable from anhedonia, a typical negative symptom).

**Criterion B:** This criterion distinguishes Schizoaffective Disorder from Mood Disorder With Psychotic Features. In prototypical psychotic Mood Disorder, the psychotic features are confined to the episodes of Mood Disorder. In contrast, in an episode of Schizoaffective Disorder, the psychotic symptoms either precede the mood symptoms or persist after the mood symptoms significantly improve. In Schizoaffective Disorder, the delusions and/or hallucinations usually persist in the absence of mood symptoms for much longer than the required two weeks.

**Criterion C:** This is the reverse of the D(2) criterion for Schizophrenia. See the discussion of Schizophrenia criterion D (page 55) for more details.

**Criterion D:** This criterion instructs the interviewer to consider and rule out a general medical condition or a substance as an etiological factor for both the mood and psychotic symptoms. See page 19 for a general discussion of how to apply this criterion. See pages 44 and 46 for a discussion of the criteria for a Mood Disorder Due to a General Medical Condition and a Substance-Induced Mood Disorder, which also apply to Psychotic Disorder Due to a General Medical Condition and Substance-Induced Psychotic Disorder.

**Ratings for Delusional Disorder (C.15-C.17)**

The SCID resumes here if criterion A for Schizophrenia is not met, thus ruling out Schizophrenia, Schizophréniform, and Schizoaffective Disorder. (Criterion D is presented first for efficiency— it rules out a Mood Disorder With Psychotic Features and Psychotic Disorder NOS.)

**Criteria D(1) and D(2):** Analogous to criterion D in Schizophrenia, this criterion indicates the differential diagnosis for individuals with mood episodes and longstanding delusions. If the delusions occur exclusively during Mood Episodes, then the diagnosis is Mood Disorder With Psychotic Features rather than Delusional Disorder, and the interviewer is instructed to skip to Module D. In contrast, if the person has persistent and prominent delusions for many years with only occasional and relatively brief Mood Episodes, the presentation is consistent with Delusional Disorder and the interviewer is instructed to continue to evaluate the remaining criteria. The middle ground, analogous to Schizoaffective Disorder, in which persistent delusions are accompanied by significant mood symptoms, is not covered by any specific category in DSM-IV. Such presentations of persistent delusions accompanied by substantial periods of mood symptoms are diagnosed Psychotic Disorder NOS with an accompanying diagnosis of either Depressive Disorder NOS or Bipolar Disorder NOS to indicate the mood episodes. For more specific instructions, see the discussion for criterion D on page 55.
**Criteria A and B:** Delusional Disorder is defined as at least a month of non-bizarre delusions that occur generally in the absence of other psychotic symptoms. However, according to criterion B, some accompanying psychotic symptoms may be present, so long as they are not prominent enough to meet the requirements of criterion A for Schizophrenia (i.e., “present for a significant portion of time during a 1-month period or less if successfully treated”). An exception is made to allow for chronic olfactory or tactile hallucinations that are thematically related to the delusion (e.g., a patient having the perception of emitting a foul body odor related to the delusion that neighbors are avoiding him).

**Criterion C:** In contrast to Schizophrenia, an individual with Delusional Disorder will often appear to have no mental illness as long as the interviewer has not tapped into the delusional system.

**Criterion E:** This criterion instructs the interviewer to consider and rule out a general medical condition or a substance as an etiological factor for both the mood and psychotic symptoms. See page 19 for a general discussion of how to apply this criterion, and pages 44 and 46 for a discussion of the criteria for a Mood Disorder Due to a General Medical Condition and a Substance-Induced Mood Disorder, which also apply to Psychotic Disorder Due to a General Medical Condition and Substance-Induced Psychotic Disorder.

**Ratings for Brief Psychotic Disorder (C.17-C.18)**

This is a rare diagnosis that applies to psychotic episodes that last at least one day, but less than one month, and are not part of a mood disorder, any of the more specific psychotic disorders described above, or a GMC or substance. Note that, unlike Schizoaffective Disorder that can be diagnosed without waiting for the individual to recover, Brief Psychotic Disorder can be diagnosed ONLY after the individual's psychotic symptoms have remitted.

**Psychotic Disorder Due to a General Medical Condition/Substance-Induced Psychotic Disorder (C.19-C.22)**

This section of the SCID is consulted only in the course of evaluating the “organic rule out” criterion that is included in the criteria sets for Schizophrenia, Schizoaffective Disorder, Delusional Disorder, and Brief Psychotic Disorder. The SCID rule is that if there is any indication that a drug of abuse, medication, or general medical condition may be responsible for the psychotic symptoms through a direct physiological mechanism, the interviewer should jump to this section to make a more definitive judgment. Please refer to the discussion of Mood Disorder Due to a General
Medical Condition on page 44 and Substance-Induced Mood Disorder on page 46 for a detailed discussion of how to evaluate these criteria.

**Psychotic Disorder NOS (C.23)**

This is the place to diagnose any psychotic disorder that doesn’t meet the criteria for the specific psychotic disorders described above. There are several examples given, but the most frequent reason for using this category in the SCID is that you know the individual has had psychotic symptoms, but you don’t have enough information to make a more specific diagnosis. This category also applies to the very brief psychotic experiences that can occur in some individuals with Borderline Personality Disorder when they are subjected to extreme stress.

**Chronology Section for Psychotic Disorders (C.24-C.25)**

Each disorder is considered “current” if there is has been a psychotic symptom at any time in the past month. Alternatively, Schizoaffective Disorder is considered current either if a psychotic symptom has been present or if the full criteria for a Mood Episode have been in the past month.

**10.6 MODULE D. MOOD DISORDERS**

Whereas Module A was for rating Mood Episodes, this module is for recording Mood Disorder diagnoses (other than Dysthymic Disorder, Mood Disorder Due to a General Medical Condition, and Substance-Induced Mood Disorder). You should go through this module if EITHER 1) there have been one or more current or past mood episodes (from Module A) AND these mood episodes have not all been subsumed as part of a diagnosis of Schizoaffective Disorder (from Module C); or 2) there have been clinically significant mood symptoms that do not meet the criteria for a mood episode AND are not just an associated feature of a psychotic disorder (e.g., not just some mild depressive symptomatology occurring during the residual phase of Schizophrenia (from Module C).

The diagnoses covered in this module include Bipolar I Disorder, Bipolar II Disorder, “Other Bipolar Disorder” (which includes Cyclothymic Disorder and Bipolar Disorder NOS), Major Depressive Disorder, and Depressive Disorder NOS. As in Module C, the task in this module is to evaluate whether the specific criteria for Mood Disorders are met based on information gathered in Modules A, B, and C. Going through this module is akin to following the DSM-IV decision tree for Mood Disorders.
Ratings for Bipolar I and Bipolar II Disorder (D.1-D.2)

The minimum requirement for a diagnosis of Bipolar I Disorder is a Manic or Mixed Episode that is not due to a substance or general medical condition and is not already part of a diagnosis of Schizoaffective Disorder (which would have been diagnosed in Module C). The minimum requirement for a diagnosis of Bipolar II Disorder is one Hypomanic AND one Major Depressive Episode, neither due to a substance or general medical condition. Bipolar II cannot be diagnosed if there has ever been a Manic or Mixed Episode. The question may arise as to how the interviewer is to know whether there have been any Mixed Episodes, since Module A does not include ratings for a Mixed Episode—only for Major Depressive, Manic, or Hypomanic Episodes. This issue is actually diagnostically relevant only for determining the type of the current episode—past Mixed Episodes are rated in the SCID as Manic Episodes, and the presence of either type warrants a lifetime diagnosis of Bipolar I Disorder. The current episode is considered to be Mixed if BOTH a current Major Depressive and current Manic Episode are coded in Module A and it is determined that the criteria have been met for both nearly every day for at least a one-week period. Note that once the diagnosis of Bipolar I or Bipolar II Disorder is made and the type of current episode specified, the interviewer is instructed to skip to the assessment for the Rapid Cycling and Seasonal Pattern specifiers on page D.3.

Rapid Cycling: DSM IV defines Rapid Cycling as four mood episodes in the past 12 months, each meeting the full criteria for severity and duration. Note that the SCID provides detailed ratings for only one episode of each type so that complete information for rating this specifier is generally lacking. Those investigators interested in a precise assessment of Rapid Cycling should refer to Module J and undertake a more detailed review of past episodes occurring in the last year.

Seasonal Pattern: Note that this specifier refers only to the seasonal occurrence of Major Depressive Episodes and does not take Manic or Mixed Episodes into consideration.

Ratings for Other Bipolar Disorders (D.4)

If criteria are not met for either Bipolar I or Bipolar II Disorder AND there are clinically significant manic or hypomanic symptoms that are not better accounted for by a psychotic disorder, then a diagnosis of Cyclothymic Disorder or another “bipolar spectrum disorder” may be warranted. Note that before one of these disorders can be considered, the interviewer must first rule out a general medical condition or a substance as the cause of the manic symptoms (see pages 44-48 for a discussion of this process).
Ratings for Major Depressive Disorder (D.6)

The diagnosis of Major Depressive Disorder requires a minimum of one Major Depressive Episode that is not due to a general medical condition or substance AND is not already included in a diagnosis of Schizoaffective Disorder (which would have already been made in Module C). Note that in order for Major Depressive Disorder to be considered recurrent, one needs only to determine that there was a period lasting at least two months in which the depressive symptomatology consistently fell below the five-symptom threshold for a Major Depressive Episode (i.e., a partial remission); not a two-month period of full remission.

Ratings for Depressive Disorder NOS (D.8)

In order to facilitate research on subthreshold depression, the SCID allows the interviewer to indicate the type of “unspecified” depression that applies. Note that Module J contains additional interview questions for the assessment of Minor Depressive Disorder, as well as for Mixed Anxiety Depressive Disorder (which is coded under Anxiety Disorder NOS in the SCID).

Mood Chronology (D.10)

The Mood Disorders module concludes with a section that allows the interviewer to specify the current status of the diagnosed Mood Disorder as well as age at onset of the first mood episode (regardless of type). The first rating indicates whether the Mood Disorder is “current,” which in the SCID means that the criteria have been met for a Mood Episode at any time in the past four weeks (a Major Depressive Episode starting five months ago that remitted three weeks ago would be considered “current” by this convention). For current episodes, the interviewer should skip to page D.11 to rate the current severity. Note that the ratings for current severity depend upon the type of current episode (e.g., the criteria for severe Manic Episode differ from those for a severe Depressive Episode). If the criteria are not currently met for a mood episode, the interviewer provides a rough indication of how long ago mood symptomatology was significant (expressed as number of months before the interview), and then specifies whether there are any current symptoms (i.e., partial or full remission).

The chronology section concludes with a rating of the Longitudinal Course Specifiers (D.12). These specifiers indicate whether there has been a period of full recovery between the two most recent Mood Episodes. For this reason, this section is skipped in cases in which there has been only a single Major Depressive, Manic, or Mixed Episode. Note that the specifier Without Full Interepisode Recovery is particularly useful when making a diagnosis of “double depression” (i.e., Major Depressive Disorder superimposed on Dysthymic
Disorder). For example, if an individual starts out with 20 years of Dysthymic Disorder since age 18, and over the past several years has had several Major Depressive Episodes superimposed on Dysthymic Disorder, the SCID diagnoses would be Dysthymic Disorder and Major Depressive Disorder, Recurrent, Without Full Interepisode Recovery. Note that if the individual is no longer in a Major Depressive Episode but has returned to his or her dysthymic baseline, the Major Depressive Episode would be coded as “in partial remission” in the chronology section.

10.7 MODULE E. SUBSTANCE USE DISORDERS

This module contains ratings for the Substance Use Disorders (Dependence and Abuse), which cover problems caused by the subject’s pattern of use of substances. Psychiatric symptoms (e.g., psychosis, depression, anxiety) related to the direct effects of the substance on the central nervous system are diagnosed as Substance-Induced Disorders and are located throughout the SCID according to the type of symptom presentation (i.e., Substance-Induced Mood Disorder in Module A, Substance-Induced Psychotic Disorder in Module C, and Substance-Induced Anxiety Disorder in Module F). The SCID separates the evaluation of Alcohol from other substances because it is legal, more widely used than other substances, and most users do not have problems with it.

Procedure For Rating Alcohol Use Disorders (E.1-E.8)

The Alcohol section begins with a series of screening questions that determine whether the individual’s pattern of alcohol use is insubstantial enough to skip the detailed evaluation of Alcohol Dependence and Abuse. Because subjects often minimize (or underestimate) their drinking habits, the interviewer should skip the Alcohol section only if there is absolutely no question that there have never been any incidents of excessive drinking or alcohol-related problems. Since the definition of Alcohol Abuse requires recurrent problems associated with alcohol, very infrequent but nonetheless heavy drinking may still warrant a diagnosis of Alcohol Abuse. As a rule of thumb, if the subject reports ever having had at least one time in which he or she had five or more drinks, acknowledges ever having a problem related to drinking, or admits that others have objected to his or her drinking, then the Alcohol Use Disorders section of the SCID should be explored.

Since a diagnosis of Alcohol Abuse is relevant only for those individuals whose pattern of use does NOT meet the criteria for Alcohol Dependence, it might seem to make sense to ask the questions for Dependence first. However, because it is expected that the majority of individuals who screen positive with these low threshold screening questions will not have Alcohol Dependence, the SCID first checks the four criteria for Alcohol Abuse. If the criteria are met for Abuse, only then is the assessment of the seven criteria
for Dependence required. However, if information from the Overview and alcohol screening questions suggests that a diagnosis of Alcohol Dependence is likely, the interviewer should start with the questions for Alcohol Dependence since, if the criteria are met for Dependence, Alcohol Abuse need not be assessed. This design minimizes the total number of substance-related questions that have to be asked-- four questions for the majority who have had as much as five drinks on one occasion but end up not ever having had Alcohol Dependence or Abuse, seven questions for those most likely to have Dependence, and eleven questions for those with Abuse (i.e., for those who admit having some problems with alcohol but not enough to suspect Dependence, the interviewer starts with the four Abuse questions; if the criteria are met for Abuse, the interviewer must then follow up with the seven questions for Dependence).

**Ratings for Alcohol Abuse (E.2-E.3)**

A rating of 3 on any of the Alcohol Abuse items depends on the subject recognizing the problem and telling you about it. A person who regularly has a few beers or a few martinis with lunch, but denies that it has ever caused problems, cannot be diagnosed with Alcohol Abuse. If you suspect that the subject is minimizing the consequences of drinking you may need to gently confront his or her denial (e.g., “it’s hard to for me to imagine that being drunk while working on a roof wasn’t dangerous. Are you sure you were functioning as well as you do when you’re not drinking?”). Interviewing informants is often crucial to the accurate assessment of Alcohol Abuse and Dependence.

In order to maximize the chances of making a diagnosis of Abuse, it is important to identify, based on the subject’s response to the screening questions, the period of time in which the Abuse criteria are most likely to have been met. If the subject has admitted during the screening a period in which his or her drinking caused problems, then certainly that period of time should be used. Alternatively, if the subject denies that alcohol has ever caused problems, the period of time in which he or she was drinking the largest quantities of alcohol would make sense. Note that in order to make a rating of 3 for a particular item, the problems must have occurred repeatedly--at least twice in a 12-month period. One arrest for driving while intoxicated doesn’t count (although it’s likely anyone who gets stopped for drunk driving has had other times when he or she drove while intoxicated and was not caught, in which case Criterion A 2 would be coded 3).

**Criterion A(1):** A rating of 3 for this item requires specific evidence that it was the effects of the alcohol use (i.e., either intoxication, withdrawal, or “hangover”) that resulted in the subject’s failure to fulfill a major role obligation on at least two occasions.

**Criterion A(2):** A common error in rating this item is to be overinclusive and assume that any level of alcohol use in a situation that requires alertness would
qualify. The item should be rated 3 only when the drinking caused sufficient impairment to create a physically hazardous condition (e.g., driving or hunting while intoxicated). Note that the question in parentheses asks the subject to judge how impaired he or she was when driving (or doing any other potentially dangerous activity). You may give the benefit of the doubt to someone who says, for example, that he can drive perfectly well after having two beers.

Although getting drunk and walking home through a dangerous neighborhood, or having unprotected sex with someone one doesn’t know very well while intoxicated is certainly risky, neither would warrant a rating of 3—the intent of this item is to rate behavior that puts the subject in immediate danger because his or her coordination or cognition is impaired by drinking.

**Criterion A(3):** This item should be rated 3 only if the legal problems are a direct consequence of the effects of alcohol (e.g., arrest for violent behavior resulting from intoxication).

**Criterion A(4):** This item is difficult to evaluate when the interpersonal conflict is possibly attributable to a relational problem rather than to a problem with the individual’s alcohol use. For example, arguments about occasional nonproblematic drinking that are initiated by a spouse who believes any drinking is evil would not warrant a rating of 3.

**“Skip” instructions at conclusion of a rating of presence or absence of Alcohol Abuse:** The skip instructions following the rating that criteria are (or are not) met for Alcohol Abuse are complicated by the fact that there are two “pathways” in the SCID that can bring you to this point.

In the first scenario, the screening questions on page E.1 indicate a lifetime pattern of alcohol use that is not suggestive of Dependence but that exceeds that admittedly low threshold “at least one occasion in which the subject had 5 or more drinks.” If the criteria have in fact been met for Alcohol Abuse during the subject’s lifetime, the interviewer must then proceed with an assessment of the criteria for Alcohol Dependence, starting on page E.4. If criteria have not been met for Abuse, and there continues to be no evidence of Dependence, the interviewer can skip to the evaluation of other substances (on page E.10). Note that the interviewer must still consider the possibility of Dependence even in the absence of Abuse because the criteria for Dependence and Abuse focus on different aspects of the problem: the Abuse criteria examine alcohol-related problems, whereas the Dependence criteria focus on loss of control. Thus, it is possible for a subject to have evidence of loss of control over alcohol use without the alcohol use leading to the specific problems covered in the Alcohol Abuse criteria set.

In the second scenario, the interviewer has reached the end of the Abuse criteria AFTER having finished the assessment of the criteria for Dependence and determining that the Dependence criteria have never been met (i.e., the screening questions on page E.1 indicated a lifetime pattern of use that suggested Dependence, causing the interviewer to start with the Alcohol
Dependence criteria). If the criteria are also not met for Abuse, the interviewer can skip to the evaluation of other substances (starting on E.10). If the criteria are met for Abuse, the interviewer is instructed to proceed to the Abuse chronology section on E.4.

**Ratings for Alcohol Dependence (E.4-E.9)**

The criteria have been re-ordered from DSM-IV in order to make them more user-friendly.

**Criterion A(3):** The intent of this item is to capture the subject’s failed attempts to put some limits on his or her drinking, e.g., “I’ll just have a few beers and then go home” or “I’ll stop at the bar for only half an hour.” Note that the breaking of these self-imposed limits (e.g., the subject ends up drinking a couple of six-packs, or staying in the bar for hours) must occur OFTEN in order to be coded 3. There is something of a paradox inherent in the evaluation of this item (and criterion A(4) as well). In order to qualify for these items, the individual must have developed enough insight about having a substance problem to want to control its use. These items are therefore impossible to evaluate in someone who has a very heavy pattern of use but denies any need to control or cut down use.

**Criterion A(4):** This item describes unsuccessful attempts to cut down or control drinking over a longer period of time; weeks, months or years, as opposed to planning for an evening’s drinking.

**Criterion A(5):** This three-part item covers the various ways in which drinking may become a central focus of the subject’s life. Reasonable people may disagree about what constitutes “a great deal of time,” and for studies in which it is critical to separate subjects who cluster around the threshold, it may be necessary to make specific study-wide rules. As a rule of thumb, two evenings a week spent drinking is not “a great deal of time”; five evenings a week is, and in between probably justifies a rating of 2.

**Criterion A(6):** The prototype for this item is a street corner alcoholic who has essentially given up all activities except those associated with drinking, but it may also be applied, for example, to an amateur athlete who has stopped doing sports because of drinking, or a person who has stopped seeing all his good friends and now hangs out with a group of heavy drinkers.

**Criterion A(7):** This item is meant to tap a pattern of compulsive use of alcohol and does not refer merely to the adverse physical or psychological consequences of drinking. In order to qualify for a rating of 3 on this item, a subject must understand that the physical or psychological problems are due to the drinking, and still be unable to stop using or cut down significantly. Examples of physical problems include cirrhosis or esophageal bleeding due to excessive
drinking; examples of psychological problems are alcohol-induced pugnacity that leads to frequent fights and blackouts. The most frequent noxious physical effect of alcohol is a hangover. When hangovers are severe and frequent, and the subject still continues to drink, a coding of 3 is justified on this item.

**Criterion A(1):** Anyone who drinks at all develops some tolerance from the time of adolescent experimenting with alcohol. This item is meant to capture those whose tolerance increased markedly from the time they began drinking fairly regularly to some later time, e.g., “I used to get drunk on 3 beers. Now I can drink two six-packs and not be drunk.”

**Criterion A(2):** Withdrawal is indicated by the development of the characteristic substance-specific withdrawal syndrome shortly after stopping or decreasing the amount of alcohol. In some cases, the individual never allows the withdrawal syndrome to develop because he or she starts drinking in anticipation of the onset of withdrawal symptoms.

**Remission Specifiers (E.8):** If the criteria are not currently met for Dependence, then one of the six remission specifiers may be applied. Note that these remission specifiers cannot be applied until after a month has elapsed in which the criteria have not been met for either Dependence or Abuse. Therefore, in those situations in which the evaluation of Abuse was skipped, the interviewer may need to review these criteria in order to decide if the Dependence is in remission. The first two (Early Partial Remission and Early Full Remission) apply when the period of non-dependence has lasted for less than 12 months. The second two (Sustained Partial Remission and Sustained Full Remission) are for more prolonged periods of nondependence, lasting longer than 12 months. Note that abstinence is not required for a subject to be in remission--drinking that does not meet the criteria for Dependence or Abuse (so-called “nonproblematic use”) could still qualify for Full Remission. Note that for subjects in settings in which access to alcohol is controlled (e.g., a drug rehabilitation center), the standard remission specifiers may not apply and the specifier “In A Controlled Environment” might be more appropriate.

**Procedures for Rating Non-Alcohol Substance Use Disorders (E.9-E.22)**

The non-alcohol substance dependence and abuse section is perhaps the most complex part of the SCID because it allows for the simultaneous rating of dependence and abuse for 10 different classes of substances. While this level of information is important for studies focusing on substance use problems, many studies are only interested in determining whether dependence or abuse has been met for ANY substance. For this reason, the SCID includes an “alternate version” of the Non-alcohol Substance Dependence and Abuse section. In this version, the interviewer decides (after the screening section) which single drug class and time period to focus on.
(presumably the period of heaviest use or most severe drug-related problems). To use this version, substitute pages E.9-E.22 with alternate pages E.9-E.18 (which are included after Module J in the SCID packet). Refer to page 74 in the User’s Guide for more instructions about how to use this section. In order to minimize the number of questions that must be asked about each substance, the SCID inquires about the level of drug use for each drug class to determine whether the seven Dependence questions or the four Abuse questions need to be asked. The procedure for using this section is as follows. Hand the subject the drug list (the last page of the SCID) and ask which drugs he or she has ever tried. For each of those acknowledged, the interviewer then asks whether the level of use ever exceeded the threshold of at least 10 times in any one-month period (or, for prescribed drugs, whether the subject has ever taken more than was prescribed or reports ever having been "hooked"). If the subject reports drug use at or above this threshold, circle a 3 for the drug class. If the reported use is below the threshold (but subject has at least admitted to using the drug on more than one occasion), circle a 2. If the subject has never used a drug from the class or used only once, circle a 1. For prescribed medications, if the subject has ever taken more than was prescribed or reports ever having been "hooked," circle a 3. If the subject has used a prescribed medication but only as directed, circle a 1. In each case of a 2 or 3 rating, obtain a description of the pattern of use. If the subject acknowledges using more than one type of drug within a particular class (e.g., barbiturates and quaaludes), the interviewer should focus on the drug used most heavily.

For each class of drug coded 3, the interviewer asks all seven Dependence questions. For each class coded 2, only the four Abuse questions are asked. For each class coded 1, no questions are asked. Note that if the level of drug use is above the threshold (i.e., the class is coded 3) so that the seven Dependence items are rated, but ultimately fewer than three items are coded 3 (so that the criteria are not met for Dependence), a diagnosis of Abuse must still be considered for that drug class. For example, let’s say the subject reports taking cocaine daily (warranting a rating of 3 on page E.10), smokes marijuana daily (also warranting a rating of 3), and uses speed a couple of times a month (warranting a rating of 2). The interviewer would then ask the seven Substance Dependence questions for the cocaine and marijuana and the four Substance Abuse questions for the amphetamine. If, after rating the criteria for Dependence it turns out that the criteria were not met for Cannabis Dependence, then the criteria for Cannabis Abuse would also have to be assessed.

When assessing Dependence (or Abuse) for more than one drug class at a time, the most efficient technique is to ask about each symptom for all of the drugs before going on to the next symptom. For example, the subject has reported using marijuana continuously, but most heavily in high school, stimulants in college, and cocaine currently. The interviewer asks "During the period in high school when you were smoking several joints a day, did you often find that you ended up smoking much more of it than you were planning to? ...how about when you were using a lot of Dexedrine in college, did you often use a lot more...? ...how about now with the cocaine, do you often use a lot
more...?" Alternatively, the interviewer can go down the list of seven symptoms for each drug separately. For example, "During the period in high school when you were smoking several joints a day, did you often find that you ended up smoking much more of it than you were planning to? ...did you try to cut down or stop? ...etc."

**Ratings for Polysubstance Dependence**

A diagnosis of Polysubstance Dependence applies when there is a period of time in which the subject is using a number of different drugs simultaneously but because the level of use of any one drug is not particularly high, criteria are not met for Dependence on any one class of drug. However, if the criteria for Dependence are applied to the entire pattern of substance use (as if a single generic “poly-drug” were being used), then a diagnosis of Polysubstance Dependence may apply.

There are two ways of making a diagnosis of Polysubstance Dependence using the SCID. One way is to identify during the drug screening process on pages E.9-E.11 a period of indiscriminant drug use. In such cases, the “Poly” column is used as if this were a single drug class in which all of the drugs used during that time period are considered as if they were in the same group. Thus, when inquiring about each Dependence criterion for the “poly” column, the interviewer might refer to the period as “that time when you were taking a lot of drugs but didn’t really care which one you were taking.” Note that making a diagnosis of Polysubstance Dependence does not preempt a diagnosis (during another time) of dependence on a specific substance. However, in some studies, if Polysubstance Dependence is established, the interviewer may not wish to spend the additional time necessary to document dependence on a specific substance or conversely, if dependence on a specific drug is established, the interviewer may not need to establish poly-drug dependence.

Whenever modifications are made in the SCID rules (such as the above) for a particular study, they should be written into the study manual so procedures will be clear to all raters.

The second way to make a diagnosis of Polysubstance Dependence in the SCID is during the final counting of Dependence symptoms on page E.16. If criteria are not met for Dependence on any one class of drug (i.e., fewer than 3 Dependence items have been coded 3), a diagnosis of Polysubstance Dependence can be made (by rating 3 in the “Poly” column) if the number of different Dependence symptoms (from 3 or more different drug classes, or from 2 classes if some symptoms of Alcohol Dependence have also been present) occurring during the same 12-month period adds up to three or greater. (The requirement that the Dependence symptoms come from three different drug classes comes from the requirement stated in the definition of Polysubstance Dependence on page E.11 that the subject was repeatedly using drugs from at least three different classes, not including caffeine or nicotine.)
Ratings for Other Substance Dependence (E.11-E.19)

**Criterion A(3):** The intent of this item is to capture the subject’s failed attempts to put some limits on his or her drug use, e.g., “I’m just going to have one joint tonight”). Note that the breaking of these self-imposed limits (e.g., the subject ends up smoking three joints) must occur OFTEN in order to be coded 3. There is something of a paradox inherent in the evaluation of this item (and criterion A(4) as well). In order to qualify for these items, the individual must have developed enough insight about having a drug problem to want to control its use. These items are therefore impossible to evaluate in someone who has a very heavy pattern of use but denies any need to control or cut down use. For example, heavy users of cannabis may be unlikely to attempt to cut down or control their use of the substance because of their perception that cannabis is harmless.

**Criterion A(4):** This item describes unsuccessful attempts to cut down or control drug use over a longer period of time.... weeks, or months as opposed to planning for a particular evening’s decision to use drugs (as in A(3)).

**Criterion A(5):** This three-part item covers the various ways in which drug use may become a central focus of the subject’s life. It is especially variable across the classes of drugs because of differences in cost, availability, legality, and the typical pattern of use of the particular substance. For example, the high cost, daily need, and relative unavailability of opioids is much more likely to result in an individual becoming totally preoccupied with the daily task of procuring them. In contrast, this item is less likely to apply to inhalants because of their low cost, wide availability in stores, and the typical pattern of intermittent use.

Reasonable people may disagree about what constitutes “a great deal of time,” and for studies in which it is critical to separate subjects who cluster around the threshold, it may be necessary to make specific study-wide rules. As a rule of thumb, two evenings a week spent smoking pot is not “a great deal of time”; five evenings a week is, and in between probably justifies a rating of 2.

**Criterion A(6):** Although the prototype for this item is a heroin addict who has essentially given up all activities except those associated with procuring and using heroin, it may also be applied, for example, to an amateur athlete who has stopped doing sports because of substance use, or to a person who has stopped seeing all his good friends and now hangs out with a group of heavy users.

**Criterion A(7):** This item is meant to tap a pattern of compulsive use of the substance and does not refer merely to the adverse physical or psychological consequences of using the substance. In order to qualify for a rating of 3 on this item, a subject must understand that the physical or psychological problems are due to the substance, and still be unable to stop using or cut down significantly. Examples of physical problems include serious damage to nasal mucosa from
sniffing cocaine or exacerbation of asthma during to smoking excessive amounts of marijuana. Examples of psychological problems are cocaine-induced paranoia, or panic attacks precipitated by marijuana.

**Criterion A(1):** The development of tolerance occurs most frequently with amphetamine, cocaine, nicotine, opioids, and sedatives (especially barbiturates). Tolerance for many drugs (e.g. cocaine, barbiturates, heroin) is usually apparent to the subject. For drugs like marijuana, where the quality of the drug varies markedly, it may not be possible to establish tolerance.

**Criterion A(2):** Withdrawal is indicated by the development of the characteristic substance-specific withdrawal syndrome shortly after stopping or decreasing the amount of the substance. In some cases, the individual never allows the withdrawal syndrome to develop because he or she starts taking more of the substance in anticipation of the onset of withdrawal symptoms. The severity and clinical significance of the withdrawal syndrome varies by class of substance. Characteristic withdrawal syndromes are most apparent with sedatives and opioids. Criteria sets are also provided for withdrawal from amphetamine and cocaine. Although withdrawal symptoms sometimes occur, no specific criteria sets are provided for withdrawal from cannabis, hallucinogens, inhalants, or PCP.

**Chronology for Dependence (E.17-E.19)** If the criteria are currently met for Dependence for a drug class, the interviewer is instructed to indicate both current severity (i.e., mild, moderate, or severe) as well as current subtype (i.e., with physiological dependence or without physiological dependence). If the criteria are not currently met for Dependence, then one of the six remission specifiers may be applied. Note that these remission specifiers cannot be applied until after a month has elapsed in which the criteria have not been met for either Dependence or Abuse. Therefore, in those situations in which the evaluation of Abuse was skipped, the interviewer may need to review these criteria in order to decide whether the Dependence is in remission. The first two (Early Partial Remission and Early Full Remission) apply when the period of non-dependence has lasted for less than 12 months. The second two (Sustained Partial Remission and Sustained Full Remission) are for more prolonged periods of nondependence, lasting longer than 12 months. Note that abstinence is not required for a subject to be in remission--substance use that does not meet the criteria for Dependence or Abuse (so-called “nonproblematic use”) could still qualify for Full Remission. The final two specifiers (On Agonist Therapy and In a Controlled Environment) are alternatives to the standard remission specifiers and apply in special circumstances and only for certain drug classes.

**Ratings for Other Substance Abuse (E.20-E.22)**

The interviewer should start the section on Substance Abuse by circling those drug classes that need to be assessed. These should include
those drug classes coded “2” on page E.11 (i.e., used more than once in lifetime but less than 10 times in any one-month period) as well as those drug classes in which it has been determined that the criteria for Dependence were not met. Note that a rating of 3 on any of the Abuse items depends on the subject recognizing that the substance is causing a problem. A person who regularly smokes a couple of joints a day but absolutely denies that it has ever been harmful cannot be diagnosed with Cannabis Abuse without some evidence of a cannabis-related problem. If it seems likely that the subject is minimizing the consequences of using drugs, the interviewer may need to gently confront the subject’s denial (e.g., “it’s hard to for me to imagine that being stoned while working on a roof wasn’t dangerous. Are you sure you were functioning as well as you do when you’re not stoned?”). Interviewing informants is often crucial to the accurate assessment of Substance Abuse and Dependence.

Note that the problems listed in the criteria must occur repeatedly in order to be coded 3—at least twice in a 12-month period. One arrest for driving while intoxicated doesn’t count (although it’s likely anyone who gets stopped for driving under the influence has had other times when he or she drove while intoxicated and was not caught, in which case Criterion A 2 would be coded 3).

**Criterion A(1):** A rating of 3 for this item requires specific evidence that it was the effects of the substance use that resulted in the subject’s failure to fulfill a major role obligation on at least two occasions.

**Criterion A(2):** A common error in rating this item is to be overinclusive and assume that any level of substance use in a situation that requires alertness would qualify. The item should be rated 3 only when the substance use causes sufficient impairment to create a physically hazardous condition (e.g., driving or hunting while intoxicated). Note that the question in parentheses asks the subject to judge how impaired he or she was when driving (or doing any other potentially dangerous activity). Although getting stoned and walking home through a dangerous neighborhood, or having unprotected sex with someone one doesn’t know very well while intoxicated is certainly risky, neither would warrant a rating of 3—the intent of this item is to rate behavior that puts the subject in immediate danger because his or her coordination or cognition is impaired by the substance.

**Criterion A(3):** This item should be rated 3 only if the legal problems are a direct consequence of the effects of the substance (e.g., arrest for violent behavior resulting from intoxication). Legal problems resulting from procurement or possession of illicit substances do not count because these are so much a function of local laws, attitudes, and enforcement policies.

**Criterion A(4):** This item is difficult to evaluate when the interpersonal conflict is possibly attributable to a relational problem rather than to a problem with the individual's substance use. For example, arguments about occasional
nonproblematic substance use that are initiated by a spouse who believes that even minimal drug use is evil and depraved would not warrant a rating of 3.

**Ratings for Substance Dependence/Abuse Using Alternative Version (E.9-E.18)**

As noted on page 68 above, an alternative version of the ratings for Non-alcohol Substance Dependence and Abuse has been provided for use in studies in which it is sufficient to document whether or not criteria have been met for lifetime Dependence or Abuse on any substance. (This is in contrast to the standard SCID module, which documents whether criteria have been met for lifetime Dependence and Abuse for each drug class). As with the standard SCID, the interviewer begins by giving the subject the drug list, asking whether any of the listed drugs have been taken in order “to get high, to sleep better, to lose weight, or to change your mood?” The interviewer then records the heaviest period of use for each drug. Based on this lifetime history of drug use, the interviewer must pick the drug class and period of time in which it is most likely that criteria have been met for dependence or abuse and indicate the class by providing a 3 rating on the appropriate column on page E.11. The target time period is typically the interval of time during which the subject reports that the drug caused the most problems. If the subject does not acknowledge any drug-related problems, then the interviewer should focus on the period of heaviest use. If the subject reports use of several different drugs over his or her lifetime, then the interviewer should select that drug which is most likely to have led to dependence or abuse. While this judgment is most typically based on the level of use (i.e., the interviewer should pick the drug which was used in the heaviest amounts), it sometimes makes more sense to focus on those drugs that are particularly likely to causing dependence. For example, given a subject with a history of daily heavy marijuana use and every other day cocaine use, the interviewer should probably focus on the cocaine use since regular cocaine use is more likely to result in dependence than regular marijuana use.

Once the drug class and time period are determined, the interviewer should consider whether lifetime Dependence on that substance is likely (e.g., if the subject reports having attended a 12-step program for that substance). If so, the evaluation should start with the criteria for Substance Dependence. Otherwise, the interviewer should begin with the criteria for Abuse. The skip instructions between the criteria for Dependence and Abuse follow the procedure used in the Alcohol section (see discussion of skip instruction on page 66). The one difference is that if criteria are not met for Dependence or Abuse for the chosen class of drug, the interviewer is asked to consider the other drug classes used over the subject's lifetime. If Dependence or Abuse is possible with another drug class, then the interviewer must return to page E.11, recode the drug class (i.e., erase the original coding of 3 and circle 3 for the next drug class being considered) and then recheck the Dependence and Abuse criteria for this different drug. This procedure should be done iteratively until all drug classes have been considered and it is clear that criteria have not been met for
Dependence or Abuse on any class. Note that if criteria are met for Abuse (but not Dependence) for a particular class, the interviewer should keep checking other drug classes to insure that the criteria would not have been met for Dependence.

10.8 MODULE F. ANXIETY DISORDERS

Because of the difficulty differentiating the symptoms of certain Anxiety Disorders from symptoms of a psychotic disorder and because anxiety symptoms are often clinically irrelevant in the presence of a psychotic disorder, some investigators may choose to skip over the assessment of these disorders in subjects with a psychotic disorder. These Anxiety Disorders include: Agoraphobia without Panic Disorder (AWOPD), Social Phobia, Specific Phobia, and Generalized Anxiety Disorder (GAD).

Ratings for Panic Disorder (F.1-F.5)

Criterion A(1): The term "panic attack" is often incorrectly used by subjects to describe any escalating anxiety, but the hallmark of a true panic attack is the sudden and intense onset of symptoms. The physical symptoms and terror are often overwhelming, and initial panic attacks may lead a patient to seek emergency care because of concerns that he or she may be having a heart attack.

The presence of a panic attack is not necessarily indicative of Panic Disorder since panic attacks can occur in the context of a number of Anxiety Disorders. For example, if a person with a snake phobia goes on a hike and has a panic attack after accidentally stepping on a snake, this would not warrant an additional diagnosis of Panic Disorder. By definition, at least two of the panic attacks in Panic Disorder must have been "unexpected." Assessing whether a panic attack was "unexpected" may be difficult because subjects with Panic Disorder commonly (and mistakenly) believe that there is a cause-and-effect relationship between the situations in which the attacks have developed and the attacks themselves. For example, a subject who experienced several unexpected attacks while shopping may assume that it was the experience of being in a crowded store that led to the attacks and therefore not consider the attack to be "unexpected." In such a situation, the interviewer should use the follow-up question, "Have you ever had a panic attack when you didn't expect it at all?" or "When you were in the store, right before you had your first attack, were you already feeling anxious or were you feeling OK?"

For some individuals, attacks occur following a frightening thought, such as worrying that something terrible will happen to them or to a loved one. Such attacks should still be regarded as "unexpected" because the concept of "unexpected" refers to the absence of a clear association between an
environmental stimulus and the occurrence of the panic attack. Common sense (we hope) will lead the interviewer not to include as "unexpected" panic attacks that occur in response to unexpected but realistic dangers, such as being mugged. Similarly, panic attacks that occur in response to delusions about being harmed should not be regarded as "unexpected."

**Criterion A(2):** The diagnosis of Panic Disorder requires that at least one of the panic attacks be clinically significant. The three subparts of this criterion present three different ways in which clinical significance may be manifested: either persistent worry about the implications of the attack (e.g., that the attack means the subject is going crazy or suffering from a medical illness), worry about having additional attacks, or a change in lifestyle (most commonly, avoidance of situations or activities or modifications to accommodate the attack, like always being near an exit, sitting on the aisle of a theater, etc.). Subjects who have had panic attacks but are not particularly bothered by them would warrant a rating of 1 for this item.

**Criteria for Panic Attack:** In DSM-IV, panic attack is defined using a free-standing criteria set that is not part of the criteria set for Panic Disorder per se. The SCID embeds the evaluation of whether the discrete episode of symptoms constitutes a true panic attack or, rather, just a limited symptom attack (i.e., less than 4 symptoms) in the evaluation of Panic Disorder.

Before presenting the 13 symptoms of a panic attack to the subject, the interviewer is instructed to first inquire about the most recent panic attack in an open-ended way (i.e., "when was the last bad one? what was the first thing you noticed?" etc.). This allows the subject an opportunity to describe the attack in his or her own words, which is helpful in determining whether the experience has the qualities of a true panic attack. This method is also helpful in encouraging the subject to focus on a single specific attack when endorsing the characteristic symptoms. Note that if fewer than four symptoms are endorsed, the interviewer should ask the subject whether he or she has had attacks during which there were more symptoms. If so, the interviewer should go back and reapply the list of 13 symptoms to this more severe attack and then confirm that such attacks have occurred repeatedly.

The requirement that the symptoms reach a peak within ten minutes is to differentiate a panic attack from slowly escalating anxiety. In fact, panic attacks often peak within seconds, and almost always within a few minutes. Although most panic attacks subside within an hour, some patients may continue to have symptoms and a high level of anxiety for hours after the peak.

**Criterion C:** This criterion instructs the interviewer to consider and rule out a general medical condition or a substance as an etiological factor for the panic attacks. Remember to carefully assess caffeine intake, and remember that caffeine is present in a variety of foods and over-the-counter medications like Anacin. Although substance use may be associated with the initial onset of
panic attacks, a substance use etiology should be considered when subsequent panic attacks occur ONLY in the context of substance use. See page 19 for a general discussion of how to apply this criterion. See pages 44 and 46 for a discussion of the criteria for a Mood Disorder Due to a General Medical Condition and a Substance-Induced Mood Disorder, which also apply to Anxiety Disorder Due to a General Medical Condition and Substance-Induced Anxiety Disorder.

**Criterion D:** This criterion asks the interviewer to consider whether the panic attacks are better accounted for by another mental disorder. This judgment depends on determining whether the panic attacks are cued by an anxiety provoking stimulus arising in the context of another disorder. For example, consider an individual with longstanding Social Phobia who has a panic attack while speaking in front of a large group of people. Since the panic attack was triggered by exposure to an anxiety-provoking situation (e.g., speaking in public) it is considered to be better accounted for by the Social Phobia. Similarly, if someone with Posttraumatic Stress Disorder develops a panic attack when exposed to a stimulus that reminds the person of the traumatic stressor, then the attack would not be considered a symptom of Panic Disorder. Note that this criterion does NOT set up a strict hierarchy between Panic Disorder and other mental disorders (i.e., DSM-IV does not instruct you to never diagnose Panic Disorder if the attacks occur during another disorder). Instead, clinical judgment is required to determine whether the other disorder “better accounts for” the panic attacks. (To maximize reliability, studies using multiple interviewers may need to establish common explicit guidelines for making this clinical judgment). The interviewer may need to set aside the evaluation of this criterion pending completion of the remainder of the SCID, if it seems likely that another disorder which accounts for the panic attacks may be present.

**Criterion B: Agoraphobia:** Some individuals with Panic Disorder manage to grit their teeth and suffer panic attacks without developing any avoidance, but most begin to associate certain situations with their panic attacks and consequently avoid those situations (or else endure them only with great anxiety). This avoidance may range from simply not driving a car because the person is afraid of having an attack while driving, all the way to never leaving home because of fears of having an attack in a place that’s not “safe.”

**Criterion B(1):** To rate this item 3, the subject should report that a situation is avoided because of fears that a panic attack is more likely to develop in that situation or that escape from the situation may be difficult or embarrassing in case of having a panic attack. In some cases, the subject may not be aware of the reason certain situations are avoided. If the avoidance develops soon after the onset of panic attacks, the interviewer may infer that the avoidance is related to the panic attacks.
**Criterion B(2):** Note that a rating of 3 can still be appropriate for a subject who is able to force himself or herself to go into the agoraphobic situations so long as there is either marked distress or the need for a companion to accompany the person.

**Criterion B(3):** This criterion is similar to criterion D in Panic Disorder in that it reminds the interviewer to consider whether the fear and avoidance may be better characterized as part of another mental disorder. Two of the most difficult boundaries are with Specific Phobia and Social Phobia. Typically, Agoraphobia involves avoidance of a cluster of situations, reflecting the general unpredictability of panic attacks. In contrast, a Specific Phobia tends to be limited to one consistently feared situation. Furthermore, the onset of Agoraphobia is related to the onset of panic attacks, whereas Specific Phobias tend to be either lifelong or related to a traumatic experience. Determining whether avoidance of social situations is related to Social Phobia or to fear of developing a panic attack in a social situation (which would warrant a diagnosis of Agoraphobia) generally depends on determining the temporal relationship between the onset of panic attacks and the social avoidance. If an individual develops social avoidance only AFTER the onset of panic attacks, then Agoraphobia is the most appropriate diagnosis. An individual with longstanding social avoidance who develops panic attacks when in social situations would better be considered to have Social Phobia. Note that this criterion does NOT preclude making a diagnosis of BOTH Panic Disorder With Agoraphobia and another disorder characterized by avoidance in the same individual (e.g., an individual with a long-standing dog phobia since childhood who develops unexpected panic attacks in situations without the presence of dogs).

**Chronology For Panic Disorder:** Note that Panic Disorder is considered to be “current” if there have been either panic attacks OR agoraphobic avoidance in the past month.

**Ratings for Agoraphobia Without History of Panic Disorder (AWOPD) (F.7-F.9)**

This disorder is analogous to Panic Disorder with Agoraphobia, but the concern is about panic-like symptoms as opposed to full-blown panic attacks. In Panic Disorder With Agoraphobia, there is anxiety about being in places or situations from which escape may be difficult or embarrassing in the event of having a panic attack. In this condition, the anxiety is focused on being in places or situations from which escape may be difficult or embarrassing in the event of having panic-like symptoms (either a specific uncontrollable symptom like loss of bowel control or else subthreshold versions of panic attacks known as “limited symptom attacks”).
**Criterion A:** When assessing this criterion, it is important to establish that the anxiety and/or avoidance is related to concerns about having panic-like symptoms and not for other reasons (e.g., a person having anxiety about going outside because he or she lives in a dangerous neighborhood).

**Criterion B:** This criterion, which requires that criteria have never been met for Panic Disorder, has been omitted from the SCID since this criterion has already been met by virtue of the branching logic that skips this disorder if criteria have been met for Panic Disorder.

**Criterion C:** The type of anxiety or avoidance seen in this condition would rarely be associated with a substance or general medical condition (except as discussed in criterion D). Nonetheless, DSM-IV requires the interviewer to rule out these etiologies.

**Criterion D:** Individuals with general medical conditions often restrict their activities and avoid situations because of concerns that the symptoms of the general medical condition may be disabling or embarrassing. This criterion clarifies that this diagnosis may be appropriate if the amount of anxiety or avoidance is unreasonable given the severity of the general medical condition. For example, avoiding driving for several weeks following a severe heart attack would certainly not warrant a diagnosis of AWOPD, whereas being housebound for two years following a mild heart attack might warrant a diagnosis.

**Ratings for Social Phobia (F.11-F.14)**

**Criterion A:** There is a wide range of social triggers that may qualify for this criterion--what they all have in common is that the subject fears acting in a way that will be humiliating or embarrassing. Some people are afraid of any kind of scrutiny--they choose to work by themselves, won’t go to parties, or out on dates because they are extremely self-conscious, and believe that others will judge them to be foolish, or stupid, or inept. (This is often a lifelong pattern, and these individuals usually also have Avoidant Personality Disorder.) Other socially phobic people are comfortable in many relationships, but uncomfortable about various situations in which they are required to “perform.” This more circumscribed form of Social Phobia includes traditional performance situations like public speaking or playing a musical instrument, as well as other behaviors that are only a performance in the person’s mind: fears about urinating in a public bathroom, writing in front of others, or eating in front of others. Individuals with performance anxiety have no problem performing the behavior when alone (e.g., giving a speech in front of a mirror). In all cases, a rating of 3 requires that the focus of the anxiety is concern about being humiliated or embarrassed by the scrutiny of others. Avoidance of a behavior because of concerns that the person’s own high standards will not be met (as in Obsessive-Compulsive Personality Disorder) would not warrant a rating of 3.
Because concerns about public speaking are so ubiquitous, it is important not to rate this criterion as a 3 for public speaking unless it is clear that the person's concerns are excessive and do not diminish with practice.

**Criterion B**: This criterion should be rated 1 if the anxiety and avoidance are erratically expressed (i.e., fear of speaking in one class, but no fear of speaking in a different class with the same number of people).

**Criterion C**: This criterion helps to set the boundary between Social Phobia and the social avoidance that is characteristic of many psychotic disorders. In a psychotic disorder, the social avoidance is usually associated with a delusional belief (e.g., persecutory delusion) that the subject believes justifies his or her social anxiety or avoidance.

**Criterion D**: This two-part criterion underscores that avoidance of social situations is not a required part of this disorder. A diagnosis of Social Phobia may also apply to those who force themselves to go to parties, give talks, or go on job interviews, but feel intensely anxious while doing it.

**Criterion E (also in Specific Phobia)**: A diagnosis of Social or Specific Phobia is not made unless the avoidance, anticipatory anxiety, or distress is clinically significant (i.e., interferes with functioning, with social activities, or with relationships, or if there is marked distress ABOUT having the phobia). Thus, for example, a public speaking phobia in a plumber who is almost never called upon to address groups of people is unlikely to meet the criterion, as is a snake phobia in someone who rarely leaves New York City. Some individuals who seriously constrict their lives to avoid social (or other phobic) situations may report a lack of distress since their phobias are never activated. A rating of 3 may still be justified if the interviewer makes a clinical judgment that the phobia has a significant negative impact on their functioning.

Often a subject will describe anxieties that he or she had as a child, and the interviewer is uncertain as to whether there was enough impairment or distress at that time to warrant a past diagnosis of a phobia. An additional guideline is: make the diagnosis if the condition was sufficiently persistent and impairing that clinical attention at that time probably would have been indicated. Thus, for example, a few weeks of anxiety about frogs with some avoidance behavior would be ignored diagnostically, but if all summer the child refused to go outside because of the possibility of seeing a frog, the past diagnosis of Specific Phobia should be made.

Note: Most potential diagnoses of phobias sink or swim on this criterion. Master SCIDders may choose to skip directly to the rating of this criterion if it seems likely that the phobia is going to turn out to be clinically insignificant.

**Criterion G**: Phobias are rarely caused by the direct physiological effects of a substance or general medical condition.
Criterion H: DSM-IV excludes a diagnosis of Social Phobia for individuals with medical or psychiatric conditions who may understandably avoid social situations because they are embarrassed about their symptoms. Such individuals, especially those who overreact to their condition or disability, may deserve a diagnosis of Anxiety Disorder NOS (see page F.40 of the SCID). For example, although this criterion does not allow a diagnosis of Social Phobia for a person with a slight stutter who won’t go on job interviews, a diagnosis of Anxiety Disorder NOS should be considered.

Ratings for Specific Phobia (F.16-F.18)

The criteria B, C, D, and E are the same as in Social Phobia.

Criterion A: The hallmark characteristic of a phobia is that the fear is way out of proportion to the degree of danger posed by the object or situation.

Criterion F: This criterion applies only to children and was added to DSM-IV to exclude transient childhood phobias.

Criterion G: Specific Phobia is, in a sense, residual to other disorders with stimulus-triggered anxiety. For example, although fear and avoidance of contamination may meet the criteria for a “dirt phobia,” if the fear and avoidance occurs as part of a contamination obsession and hand washing compulsion in Obsessive Compulsive Disorder, then an additional diagnosis of Specific Phobia is not made.

It should be noted that a diagnosis of Specific Phobia can be made along with one of these other disorders if the fear and avoidance are unrelated to the other disorder. For example, a person with Panic Disorder may avoid many different situations or activities because of the fear of having a panic attack, but may also have specific phobias that are unrelated to the Panic Disorder. It is up to the interviewer to get enough information to judge whether, in addition to agoraphobia, there are fears (e.g., of dogs, of spiders) that are unrelated.

Ratings for Obsessive Compulsive Disorder (OCD) (F.20-F.23)

Obsessions, Criterion A: The most common diagnostic problem is distinguishing true obsessions from other repetitive distressing thoughts, like excessive worries about realistic concerns, depressive ruminations, and delusions. Obsessions have an intrusive, inappropriate, and “ego-alien” quality and are experienced by the subject as something different and stranger than the worries or preoccupations that characterize Generalized Anxiety Disorder or a normal reaction to life's unpredictability. The recurrent, intrusive, and anxiety-provoking thought while driving, that one ran over a small child without realizing it is an
obsession. Spending an equal amount of time worrying about one's retirement is more likely to be an aspect of Generalized Anxiety Disorder. Unlike obsessions, depressive ruminations and delusions are generally not perceived as intrusive or inappropriate, but are understood by the subject as a valid focus of concern, even if he or she realizes that the concern is excessive and tries to stop thinking about it.

In those situations when the differential diagnosis is particularly challenging, it may be useful to remember the fact that obsessions and compulsions usually go together (in fact, 90% of the time according to the DSM-IV OCD field trial). Therefore, in trying to distinguish between an OCD obsession and other repetitive thoughts, the clinching point may be whether compulsions are also present.

**Compulsions, Criterion A:** Compulsions are distinguished from other forms of repetitive behavior by the underlying motivation for the behavior—to reduce or prevent the anxiety associated with an obsession. For example, hand washing alleviates the anxiety triggered by the obsession that one is contaminated; repeating a prayer exactly 36 times is meant to counteract the distress caused by having an obsessive obscene thought. Determining that the behavior is intended to reduce the anxiety accompanying an obsession is very helpful in differentiating a compulsion from other repetitive behaviors like tics and stereotypies. The most common compulsions are behaviors like hand washing, repetitive touching or picking up and replacing an object over and over again, or mental acts such as counting or repeating a word or phrase over and over.

**Criterion B:** The prototypical patient with OCD is aware that his or her obsessions and compulsions are unreasonable (e.g., that it is ridiculous to be concerned about contamination from germs that might arise from touching newspapers). Over time, some individuals with OCD lose insight as to the excessive nature of their obsessive concerns or compulsive behaviors and may in a later stage of the illness describe the obsessions or compulsions as being reasonable. For such individuals, it is essential to establish whether at some time in the past (usually early in the course of the illness) the obsessions and compulsions were regarded as unreasonable (e.g., “when the hand washing first started, did you feel that you were washing your hands much more than you should or than really made sense?”). For those individuals who no longer recognize that the obsessions or compulsions are excessive or unreasonable, the specifier “With Poor Insight” may be noted.

**Criterion C:** This criterion requires that the obsessions or compulsions be clinically significant. Note that the standard DSM-IV clinical significance criterion also includes a phrase indicating that the obsessions or compulsions may be “time consuming (take more than an hour a day).” This clause allows the interviewer to conclude that impairment is present even in the face of the patient’s apparent lack of concern about the behavior or the rationalization that it is useful.
Criterion D: An additional diagnosis of OCD should not be given along with another mental disorder if the repetitive thoughts or behaviors can be considered to be features of the other mental disorder. Most of the examples of symptoms of other disorders that are given in the SCID do not really meet the test of “intrusive and inappropriate.” For example, when a patient with Anorexia Nervosa is preoccupied with measuring the exact number of calories in the food she eats, she may agree only that it is excessive, not foolish. However, if the obsessions or compulsions are clearly symptoms of another disorder, the interviewer may skip out of the diagnosis of OCD without spending a lot of time deciding whether the symptoms are “intrusive and inappropriate” or just “excessive.” (Of course, Anorexia does not protect someone against OCD; the patient with Anorexia may also have hand washing rituals that are unrelated to her eating disorder, and therefore be given both diagnoses.)

Criterion E: OCD is rarely due to a GMC/Substance.

Common pitfall: Neophyte interviewers may become obsessively concerned with the precise meaning of each word in the definitions and assign a diagnosis to a subject who does not deserve it. Many people have some obsessive thoughts or compulsive behavior, but OCD is a severe and relatively infrequent condition.

Ratings for Posttraumatic Stress Disorder (PTSD) (F.25-F.29)

After being available only as an optional module in the DSM-III-R SCID, PTSD is now added to the standard SCID for DSM-IV. The evaluation of PTSD begins with a screen that first reviews the individual’s lifetime history of exposure to severely traumatic experiences and then determines whether any of these traumatic experiences have been re-experienced in the form of dreams, flashbacks, intrusive thoughts, or strong reactions when in situations that are reminiscent of the trauma. If so, the interviewer should proceed with the evaluation of PTSD, focusing on the event identified in the screen. If more than one traumatic experience is reported, the interviewer should ask the subject to choose the one that seems to have affected him or her the most. If, during the evaluation of PTSD for this particular stressor, it becomes clear that the criteria for PTSD are not being met, the interviewer should determine whether one of the other stressors might in fact have had a greater impact on the individual, and then re-evaluate the criteria in relation to this different stressor.

Criterion A(1): In evaluating whether a stressor qualifies as a potential source of PTSD, both the type of stressor (“actual or threatened death or serious injury or threat to the physical integrity of self or others”) and the context of exposure (“experienced, witnessed, or confronted with”) should be considered. In DSM-IV,
stressors are limited to events that pose a threat to life, limb, or physical integrity. Stressors that, while distressing, are not life-threatening (e.g., being humiliated by a boss at the office) do not warrant a rating of 3 for this item. Although the prototypic stressor for PTSD is a wartime combat experience, the concept has been expanded to include other life threatening experiences like being a victim of a serious crime, accident, or disaster. The phrase "threat to physical integrity" includes all experiences of sexual assault or sexual molestation, not just those in which the victim perceives a threat of violence. The context of the exposure includes having one's life threatened; having the direct personal experience of seeing someone else being threatened, injured or killed; or hearing the news of a loved one being hurt. It is not meant to include more indirect and impersonal experiences such as hearing a news report of a catastrophe occurring to strangers. Similarly, the expected death of a loved one of natural causes at an advanced age does not qualify as a PTSD stressor.

**Criterion A(2):** This criterion requires that the person be profoundly affected by the stressor and react to it with extreme feelings of "fear, helplessness, or horror." Children are less likely to articulate their feelings and this item may be inferred by a change in their behavior.

**Criterion B:** The re-experiencing of the traumatic event can occur spontaneously (intrusive memories, flashbacks, or dreams) or can be triggered by a wide variety of stimuli that remind the person of the traumatic event. For example, smoke from a campfire may produce profound terror in someone who has been trapped in a house fire. Flashbacks to wartime may be triggered by loud noises, seeing war movies, or tropical rainstorms. In some cases, the trigger may be a symbolic representation of the actual stimulus (e.g., a policeman for a concentration camp survivor). Occasionally, it may be difficult to differentiate a flashback from a psychotic experience. In contrast to psychotic symptoms, the sense that one is reliving the traumatic experience in PTSD is transient, self-limited, and understandable in the context of the exposure to the prior stressor. Note that the re-experiencing must be persistent—a few nightmares or intrusive memories don’t satisfy this criterion.

**Criteria C and D:** These criteria include symptoms that are much less specific than those in A and B, and are seen in many other disorders. Many people, for instance, try to avoid talking or thinking about bad things that have happened to them, whether or not the bad things were traumatic. Diminished interest, detachment, a restricted range of affect, insomnia, difficulty concentrating, etc., may be symptoms of a Depressive Disorder or of a Personality Disorder. It is important that the interviewer clarify that the symptoms in C and D developed after the trauma. (In the case of a childhood trauma, it is impossible to know what the person would be like had he or she not had the experience. Following the SCID principle that one does not make a diagnosis without the evidence, we would be hesitant to diagnose PTSD in an adult who has had the symptoms as long as he or she can remember.)
**Criterion E:** The minimum duration requirement for a diagnosis of PTSD is one month. For extreme reactions to extreme stressors lasting for less than one month, consider a diagnosis of Acute Stress Disorder, which is evaluated in (optional) Module J.

**Criterion F:** If, at this point in the interview, you have any doubt about whether the syndrome causes significant distress or impairment, it probably doesn’t!

**Ratings for Generalized Anxiety Disorder (GAD) (F.31-F.34)**

Because of the difficulty in making a reliable diagnosis of Generalized Anxiety Disorder, the SCID allows a diagnosis of GAD only if it is currently present (i.e., during the past six months).

**Criterion A:** This describes the person who may be known by acquaintances as a "worry wart" or a "nervous Nellie." The anxiety or worry is not focused on one or two issues, but is panoramic. "Nellie" worries about the safety of her children, the possibility of being late for an appointment, not having enough time to finish a project, what to wear to a party, whether her job is in jeopardy, whether there are jellyfish in the water, etc. She worries much of the time, and everyone she knows thinks it is excessive.

**Criterion B:** Recognizing that the worry is excessive, a person with this problem will often tell himself to cut it out, and try to think about something else, but will find himself drifting inexorably back to whatever worry is preoccupying him at the time.

**Criterion F(2):** Generalized anxiety is more commonly an associated feature of a Mood or Psychotic Disorder than it is indicative of Generalized Anxiety Disorder. This criterion is presented out of the DSM-IV order to allow the interviewer to skip out of the evaluation of GAD if the anxiety is a feature of another disorder. However, if the period of generalized anxiety clearly precedes the onset of a Mood or Psychotic Disorder, then both diagnoses can be given.

**Criterion C:** Note that, like the generalized anxiety, some of these symptoms must also be present "more days than not" for a period of at least six months.

**Criterion D:** Anxiety and worry are important components of many mental disorders. An additional diagnosis of GAD is appropriate only if there are additional symptoms of anxiety and worry that are not part of this other disorder.

**Criterion E:** This criterion helps to set the boundary between the clinically significant anxiety in GAD and "normal" anxiety (e.g., "walking worried"). The anxiety and worry should be considered clinically significant only if they are sufficiently severe to caused marked distress or impairment in functioning.
**Criterion F:** This criterion instructs the interviewer to consider and rule out a general medical condition or a substance as an etiological factor. See page 19 for a general discussion of how to apply this criterion. See pages 44 and 46 for a discussion of the criteria for a Mood Disorder Due to a General Medical Condition and a Substance-Induced Mood Disorder which also apply to Anxiety Disorder Due to a General Medical Condition and Substance-Induced Anxiety Disorder.

### 10.9 MODULE G. SOMATOFORM DISORDERS

The common essential feature of the Somatoform Disorders is the presence of physical symptoms that suggest a physical illness but are not fully explained by a general medical condition, by the direct effects of a substance, or as a culturally sanctioned behavior or experience. Body Dysmorphic Disorder, which entails exaggerated concern about physical appearance, is included among the Somatoform Disorders because, as with the other Somatoform Disorders, patients with the disorder typically first present in medical settings. It is often extremely hard to differentiate physical complaints with a psychological etiology from as-yet-undiagnosed medical problems. To do so on the basis of reports of partially-remembered past symptoms is even harder. Therefore, the SCID requires that there must be current signs of a Somatoform Disorder.

The Somatoform Disorders section begins with screening questions that will allow the interviewer to skip to the next module if there is no evidence of any current Somatoform Disorder. The first two screening questions check for a history of physical complaints with a follow up question (“Was the doctor always able to find out what was wrong...?”) serving to help establish if the physical complaints have been unexplained. The third question (“Do you worry much about your physical health?”) screens for Hypochondriasis, and the final question (“Some people are bothered by the way they look. Is this a problem for you?”) screens for Body Dysmorphic Disorder.

**Ratings for Somatization Disorder (G.1-G.5)**

The essential feature of Somatization Disorder is multiple “somatoform” symptoms occurring over several years. Criterion B specifies the required pattern of somatoform symptoms: at least one pseudoneurological symptom, pain symptoms in at least four different anatomical sites, two gastrointestinal symptoms, and one sexual symptom. Note that the specific symptoms are included as examples in DSM-IV and are not meant to serve as an exhaustive list of acceptable symptoms. Criterion B(4) is listed first to facilitate rapid skipout from the evaluation of this disorder, since pseudoneurological symptoms are less common than the other types of symptoms.
In evaluating each symptom, criteria (1), (2), and (3) included in the box at the top of page G.2 must be met in order for the symptom to count toward a diagnosis of Somatization Disorder. Criterion (1) requires that the symptom be clinically significant, i.e., severe enough to cause the subject to seek treatment, or else that it leads to impairment. Criterion (2) serves to establish that the physical complaint has a psychological component. This entails a judgment that either the symptom cannot be fully explained by a general medical condition or substance or, in the case of a comorbid general medical condition, that the symptom is in excess of what is expected given the physical and laboratory findings associated with the general medical condition. Needless to say, this judgment can be difficult (or impossible) to make during an interview and usually requires contact with the subject's general medical provider or a review of the subject's medical records. Criterion (3) requires the interviewer to make a judgment as to whether the subject is lying about the origin of the physical symptoms. Note that the presentation of the criteria differs from DSM-IV--the criteria appearing in the box on page G.2 are included as part of criteria A and C in DSM-IV.

**Ratings for Pain Disorder (G.6)**

The diagnosis of Pain Disorder should be reserved for those patients for whom psychological factors play an important role in the pathogenesis of the pain. Because pain is a common associated feature of other DSM-IV disorders (e.g., Major Depressive Disorder), Pain Disorder is not given as an additional diagnosis unless it is so severe and persistent that it becomes a main focus of clinical attention.

Pain Disorder includes two subtypes to allow the interviewer to indicate the relative contribution of physical and psychological factors to the etiology of the pain. Pain Disorder Associated With Psychological Factors describes those situations in which either there is no known medical condition accounting for the pain or any concurrent medical condition does not play a major role in its onset, severity, exacerbation, or maintenance. The subtype Pain Disorder Associated with Both Psychological Factors and a General Medical Condition is more common and applies to those cases in which some combination of physical and psychological factors are present and contribute to the etiology of the pain.

**Ratings for Undifferentiated Somatoform Disorder (G.8)**

Undifferentiated Somatoform Disorder is a residual category that applies to unexplained physical complaints (lasting a minimum of six months) that do not meet criteria for another Somatoform Disorder. For this reason, its evaluation is skipped if Somatization Disorder or Pain Disorder has already been diagnosed. As in Somatization Disorder, the physical complaints must be clinically significant and not fully explained by a general medical condition or
substance. Unlike Somatization Disorder, this disorder is not diagnosed if the complaints are accounted for by another mental disorder, like a Mood Disorder.

**Ratings for Hypochondriasis (G.9)**

The essential feature of Hypochondriasis is preoccupation with the fear of having, or the belief that one has, a serious disease. This is in contrast to the other Somatoform Disorders in which the subject’s primary focus is on the physical symptom itself. As with the other Somatoform Disorders, it is important to make sure that the subject has had an appropriate medical evaluation before assuming that the preoccupation is unwarranted. Consultation with the subject’s physician may be necessary.

**Ratings for Body Dysmorphic Disorder (G.10)**

The evaluation of Body Dysmorphic Disorder is generally more straightforward than the evaluation of the other Somatoform Disorders since the pathological nature of the subject’s concern about appearance does not usually require a medical evaluation. However, in some cases the boundary between this disorder and "normal" concerns or dissatisfaction about appearance can be difficult to discern. The diagnosis should be reserved for those who become preoccupied by their supposed deformity or are tormented by it. Most commonly the concerns about physical appearance are centered on the shape, size or some other aspect of the face or head (e.g., hair thinning, acne, wrinkles, scars, vascular markings, paleness or redness of the complexion, swelling, facial asymmetry or disproportion, excessive facial hair). However, any other part of the body may be the focus of attention and dissatisfaction (e.g., the genitals, breasts, buttocks, abdomen, arms, hands, feet, legs, hips, shoulders, spine, larger body regions, or overall body size).

**10.10 MODULE H. EATING DISORDERS**

**Ratings for Anorexia Nervosa (H.1-H.2)**

*Criterion A:* Although abnormally low weight is necessary for a rating of 3, it is not sufficient. There must be evidence that the person is underweight because of a "refusal" to maintain a normal body weight. The determination as to whether the person’s weight is being maintained at a significantly-below-normal level is a clinical judgment. The "below 85%" threshold is merely a guideline and is not intended to be a strict cut-off. Determining "expected" weight ranges can be done by referring to one of several published versions of the Metropolitan Life Insurance Tables or pediatric growth charts, or by calculating whether the "body
mass index” [i.e., weight in kilograms / (height in meters)²] is less than 17.5 kg/m².

**Criterion B:** This criterion expresses the reason for the refusal to maintain a normal weight: an intense (and unreasonable) fear of becoming fat that persists despite the abnormally low weight.

**Criterion C:** This criterion includes three forms of characteristic distorted thinking, the presence of any one of which would warrant a rating of 3: 1) a marked distortion in the way body size and shape are experienced (e.g., the person is emaciated but still points to a body part that seems "flabby" and needs further reduction); 2) body shape and weight is the central factor in determining self-esteem; and 3) denial of the extent and danger of the weight loss.

**Criterion D:** Irregular periods do not count--there must a time during which at least three consecutive periods have been missed.

**Specifiers:** Individuals with Anorexia Nervosa who also engage in binge eating or purging behaviors are assigned to Binge Eating/Purging Type and are not given an additional diagnosis of Bulimia Nervosa. Although "regular " binge eating or purging is required for the Binge Eating/Purging Type, the frequency does not have to be as high as for Bulimia Nervosa (i.e., twice a week for three months).

**Ratings for Bulimia Nervosa (H.4-H.5)**

**Criterion A:** Episodic bursts of binge eating must be distinguished from a pattern of generalized overeating and from isolated episodes of overeating that are context-specific (e.g., at an all-you-can-eat restaurant or a celebration in which there is unlimited food). Binge eating occurs during a discrete period of time, involves consuming a huge number of calories, and is characterized by the sense of having lost control. Although the person may have a feeling of gratification or a reduction in anxiety during the binge, afterwards he or she typically feels uncomfortable, guilty, disgusted, or ashamed. The type of food consumed during binges varies, but usually includes sweet, high calorie treats such as ice cream or cake. Since some subjects may report having had "binges" involving relatively small amounts of food (e.g., eating three cookies), it is important to inquire specifically about the quantity and type of food consumed.

**Criterion B:** Binge eating by itself is not sufficient to make the diagnosis. It must be accompanied by inappropriate compensatory mechanisms intended to counteract the effects of the binges. The most common of these compensatory behaviors is some form of purging (self-induced vomiting or laxative abuse). Less common compensatory behaviors include fasting, excessive exercise, and manipulation of insulin dose by diabetics. Individuals are often very embarrassed about both their binge eating and their compensatory mechanisms
(particularly those related to purging). Such information is therefore often not volunteered and emerges only with direct questioning.

**Criterion C:** The minimum frequency of twice a week applies both to the binges and to the compensatory mechanisms, with the presumption that these generally occur together.

**Criterion D:** This criterion is similar to criterion C in Anorexia Nervosa and describes the cognitive distortions that are invariably present.

**Ratings for Binge Eating Disorder (H.7)**

Binge eating disorder is an Appendix B research category (i.e., not an “official” DSM-IV category) included in the SCID because of recent evidence of its high prevalence and validity as a diagnostic category. It is defined as regular binge eating (see Criterion A for Bulimia Nervosa) without the use of inappropriate mechanisms to compensate for the effects of the binge eating. Note that the minimum binge frequency in Binge Eating Disorder (at least two days a week for six months) differs from the requirement in Bulimia Nervosa (twice a week for three months).

**10.11 MODULE I. ADJUSTMENT DISORDER**

In most cases, this module is skipped during the administration of the SCID because another more specific diagnosis has already been made. The interviewer needs to consider this module only if there is a current problem described in the overview, but no other Axis I disorder has been identified by the SCID to account for it. The border between Adjustment Disorder and ordinary problems of life may be clarified by the notion that Adjustment Disorder implies that the severity of the disturbance is sufficient to justify clinical attention or treatment.

**10.12 MODULE J. OPTIONAL DISORDERS**

In a sense, all of the modules of the SCID are “optional” since researchers are encouraged to customize the SCID to meet their particular needs. This module contains several disorders considered to be of especially narrow interest. It contains ratings for Acute Stress Disorder (an acute form of PTSD), two disorders that are included in the DSM IV Appendix B (Minor Depressive Disorder and Mixed Anxiety Depressive Disorder), and finally a section that allows researchers to document the specific symptoms that characterize each and every past mood episode.
**Acute Stress Disorder:** This disorder was not included in the F module of the SCID because it is expected to be of interest only in studies investigating the acute effects of trauma occurring in the immediate aftermath of the traumatic experience (i.e., within the first month). A number of the criteria for Acute Stress Disorder are the same as those for PTSD. Therefore, the interviewer must start with the SCID section for PTSD and first evaluate those criteria also included in PTSD (i.e., criteria A, B, C, and D). If the duration of the symptoms is less than one month, the interviewer is instructed to skip to page J.1 and then evaluate those criteria that are unique to Acute Stress Disorder.

**Minor Depressive Disorder:** This is a subthreshold form of Major Depressive Disorder in which, like Major Depressive Episode, there are depressive symptoms for most of the day, nearly every day, for a period lasting at least two weeks. However, unlike Major Depressive Episode, fewer than five depressive symptoms have been present. In DSM-IV, this condition is diagnosed as Depressive Disorder NOS. In the SCID, the criteria for Minor Depressive Disorder are (optionally) evaluated when rating Depressive Disorder NOS in Module D.

**Mixed Anxiety Depressive Disorder:** This is a disorder characterized by a mixture of mood and anxiety symptoms that are subthreshold to any of the specific Mood and Anxiety Disorders. In DSM-IV, this condition is diagnosed as Anxiety Disorder NOS. In the SCID, these criteria are (optionally) evaluated when making a rating of Anxiety Disorder NOS.

**Ratings for Multiple Past Mood Episodes:** Some investigators may be interested in coding the symptom profiles for recurrent mood episodes, not just the current (or one past) episode as is done in the A Module. It will take a good deal of time to obtain this information, so for each study there should be a priori decisions about: 1) the maximum number of episodes to code; 2) if the number of episodes coded is limited, how to choose which episodes to code (e.g., the most severe, only those that are seasonal, etc.) and 3) how far into the subject’s past to search for episodes since, in general, the farther away the episode is in time, the less well it will be remembered (and the less reliable the ratings). With the ground rules for the study specified, the interviewer should first identify and date the episodes that will be coded, taking particular care to anchor them in time in ways that the subject will remember (e.g., "the summer before your first year in college," “January 1985, when you first moved to Chicago,” etc.). Having recorded the dates of the episodes to be reviewed, the interviewer should then go through the list of symptoms for each episode in turn. This section of the SCID may also be used to record the details of mood episodes documented in medical records.
11. TRAINING

Ideally, training should involve the following sequence:

1. Study the Basic Features, Conventions and Usage, and DO’s and DON'Ts sections in this manual.

2. Carefully read through every word of the SCID, making sure that you understand all of the instructions, the questions, and the diagnostic criteria. As you are reading through each module, refer to the corresponding User’s Guide section of Special Instructions for Each Module. Review the Diagnostic Features and Differential Diagnosis sections of DSM-IV text for those disorders included in the SCID.

3. Now practice reading the SCID questions aloud so that eventually it sounds as if SCID is your mother tongue.

4. Try out the SCID with a colleague (or significant other) who can assume the role of a subject.

5. Watch the videotape training program: SCID 101. Please refer to the SCID web site (www.scid4.org) for information about the contents of the videotapes and how to order them.

6. Role-play the cases (see Appendix B) with a colleague. These have been designed to take you through the SCID modules, not necessarily to demonstrate your dramatic talent.

7. Try out the SCID on actual subjects who are as representative as possible of those who will be included in your research study. If possible, these rehearsals should be joint interviews with all raters making independent ratings, followed by a discussion of the interviewing technique and all sources of disagreement in the ratings.

8. If possible, do a test-retest reliability study in which the interview is repeated with the same subject within a short period of time by a second interviewer. You will learn more from such a study if you videotape or audiotape the interviews, then have each interviewer listen to and rate the audiotape of the other interviewer, followed by a discussion of sources of disagreement.

   A test-retest reliability study may be impractical for some investigators. A less rigorous procedure for assessing the reliability of interviewers is to make a series of audio or videotapes, suspending the skip-outs for all the diagnoses that are of interest, and have each tape
rated by all the interviewers. In such a procedure, if the answer to the initial screening question (e.g., “Have you ever had a time when you were depressed or down for most of the day nearly every day?”) is anything other than “No,” the interviewer continues to ask all the subsequent questions. Raters will not know what judgments the interviewer is making, and the reliability of the diagnosis, as well as of the symptom ratings, can be assessed. In general, we would recommend a minimum of ten joint interviews, although the more the better. Another rule of thumb is to do enough interviews so as to have at least five cases of each type of diagnosis that you are interested in studying. For example, if you are doing a study in which you are identifying subjects with Panic Disorder and/or Generalized Anxiety Disorder, there should be enough interviews conducted for the purposes of determining reliability so that you end up with at least five cases of Panic Disorder and five cases of Generalized Anxiety Disorder.

9. Investigators who are planning studies may wish to contact us about procedures for training their raters. The nature of the training program depends on the number of raters being trained, as well as practical considerations such as funding and the availability of trainers. A training program may range from simply purchasing a copy of SCID 201, to our running a two-day training workshop at your site and reviewing a series of taped interviews made by your interviewers.

Supervisors of SCID interviewers may find the evaluation form (Appendix C) useful for improving the quality of the interviews. In many studies it is useful for the interviewer to write a one-paragraph narrative describing the symptoms that justify the diagnosis. This helps both editors and supervisors to check for errors.

10. Finally, we list the four most common errors of new SCIDders, in order to emphasize the areas to which you should pay special attention:

1) the description of behavior or symptoms is insufficient to rate the criterion.

2) the interviewer mistakenly circles a 1 for an exclusion criterion, resulting in a trip down the wrong branch of a decision tree.

3) the interviewer fails to follow the skip-out instructions, and therefore follows the wrong branch of a decision tree.

4) the overview is too skimpy, or too unfocused (and therefore LONG) to enable the interviewer to make diagnostic hypotheses with any confidence.
12. RELIABILITY AND VALIDITY

Traditionally, assessment instruments are presented with data supporting their "reliability" and "validity." Reliability for diagnostic assessment instruments is generally evaluated by comparing the agreement between independent evaluations by two or more interviewers across a group of subjects. The results are usually reported with a statistic called kappa that takes into account agreement due to chance (Spitzer, et. al., 1967). Because the SCID is a not a fully structured interview, and requires the clinical judgment of the interviewer, the reliability of the SCID is very much a function of the particular circumstances in which it is being used.

Using an earlier version of the Axis I SCID, data were collected on 506 pairs of interviews at six sites in a test-retest reliability study (Williams, et. al., 1992). A very stringent test of the SCID was conducted in which the subjects were selected randomly and the interviewers had no access to charts or treatment staff. The kappas for the Axis I SCID varied greatly by diagnosis and by site, but generally fell somewhere among those reported for other diagnostic instruments, such as the NIMH Diagnostic Interview Schedule (DIS) (Robins et. al, 1981), and the Schedule for Affective Disorders and Schizophrenia (SADS) (Endicott and Spitzer, 1978). A number of newer studies using the SCID and focusing on particular diagnostic groups have reported much higher kappas, ranging from .70 to 1.00. These have used joint or videotaped interviews in determining reliability, and therefore produce higher kappas because of the absence of information variance. (Segal et. al., 1993, 1994, 1995; Schlenger et. al., 1992; Strakowski, et. al., 1993, 1995; Stukenberg, et. al., 1990).

Kappas for the SCID-II on 226 subjects (First, et. al., 1995) were similar to test-retest kappas reported for other personality assessment instruments, such as the Personality Disorders Examination (PDE) (Loranger, et. al., 1987) and the Structured Interview for DSM-IV Personality Disorders (SIDP) (Stangl, et. al., 1985). More recent studies using the SCID-II have reported kappas of .65 to 1.00 (Arntz, et. al., 1992; Brooks, et. al., 1991; Fogelson, et. al., 1991; Malow, et. al., 1989; O'Boyle and Self, 1990; Renneberg, et. al., 1992; Wonderlich, et. al., 1990).

The validity of a diagnostic assessment technique (procedural validity) refers to the agreement between the diagnoses made by the assessment technique and some hypothetical "gold standard." Unfortunately, a gold standard for psychiatric diagnosis remains elusive. There is obvious difficulty in using ordinary clinical diagnoses as the standard, since structured interviews have been specifically designed to improve on the inherent limitations of an unstructured clinical interview. Spitzer has proposed a "LEAD" standard that could be used to evaluate the procedural validity of structured diagnostic interviews (Spitzer, 1983). This standard involves longitudinal assessment (L),
done by expert diagnosticians (E), using all data (AD) that are available about the subjects, such as family informants and the observations of clinical staff. Although conceptually the LEAD standard is appealing, the difficulty in implementing it accounts for its limited use. The only study (Skodol, et. al., 1986) using the LEAD standard to evaluate structured diagnostic interviews compared the procedural validity of the SCID-II with an early version of the Personality Disorders Examination. The results indicated comparable, but low, agreement with the LEAD standard.

13. DATA PROCESSING

Unlike some other structured diagnostic interviews, the SCID does not require the use of a computer program to make the final DSM-IV diagnoses. However, to facilitate statistical analysis by computer and facilitate comparison of data between studies, both the Summary Score Sheet and the SCID modules have data field numbers on the right hand side of each page. For most studies, data analysis will be confined to the Summary Score Sheet. Other studies that are interested in the specific ratings made for the diagnostic criteria will need to utilize the fields from the individual SCID modules.

Several relevant software packages are either currently available or in development from Multi-Health Systems (www.mhs.com). Please refer to the “Computer Software and the SCID” on the SCID web site (www.scid4.org) for the most up-to-date information.
14. REFERENCES


15. APPENDIX A: Guidelines for Customizing the SCID for Particular Studies

1. What do you really need?

Interviewers should not be using a SCID that includes diagnoses that they will not be assessing. A customized, stripped-down SCID not only saves trees, but also causes less confusion for neophyte interviewers. The SCID was designed with separate modules for each class of diagnoses. If there are classes of diagnoses that will not be assessed in a particular study, the entire module (and the corresponding section of the scoresheet) may be eliminated. For example, in a study in which only Mood, Psychotic and Substance Use disorders are being assessed, SCID modules F, G, H and I may be eliminated. Note that since the assessment of Mood Disorders requires an inquiry about psychotic symptoms (Modules B and C, or B/C), and the differential diagnosis of Psychotic Disorders also involves assessing mood episodes, in most cases Modules A, B (or B/C) and D must be used together.

The elimination of entire modules is the simplest modification of the SCID. For many studies, modifications involve the elimination of specific disorders or subtypes, or time frames. For example, an investigator may need to document a current Major Depressive episode, but may not be interested in lifetime episodes or whether the major depressive episode confirms to a particular subtypes (e.g. Postpartum, Melancholic, Atypical). In such a case, the SCID can be customized, eliminating the subtype or disorder pages from the module. WARNING: eliminating the subtypes often means changing the "GO TO" instructions on preceding pages, so these must be checked carefully when such a modification is made. Using the example above, at the bottom of page A5 (Item A28), after a Major Depressive Episode is documented, the instruction "GO TO NEXT MODULE" should be inserted so the interviewer does not continue with an assessment of a past Major Depressive Episode. The subtypes eliminated from the SCID should also be removed from the Scoresheet.

2. Exclusion Criteria

Treatment studies usually have specified exclusion criteria, so that if particular diagnoses are made, the subject is excluded from the study, and there is no point in continuing with the SCID interview. At each point in the SCID where an exclusion diagnosis is made, the instruction "EXCLUDE FROM STUDY - END OF SCID" should be inserted. For example, in a trial of a new drug for Major Depressive Disorder, the investigator may want to exclude all subjects with a history of a Manic Episode. If Item A99 (Manic Episode criteria A, B, C and D are coded "3") is true, the subject has a diagnosis of a current Manic Episode, and the EXCLUDE FROM STUDY statement should be inserted. The same is true for item A142, past Manic Episode. When the EXCLUDE FROM STUDY instruction is encountered, the interviewer should stop the SCID and gently dismiss the subject, perhaps offering other, non-study, options for treatment.
In many studies, the exclusion criteria do not overlap exactly with SCID conventions. In the example above the investigators may accept subjects with a history of drug or alcohol diagnoses, unless they are present during the past year. The substance abuse and dependence questions would have to be modified to inquire only about the past year, rather than lifetime. If a subject meets criteria for any substance abuse or dependence in the past year, the EXCLUDE FROM STUDY message should appear (e.g. items E6, E92, E93, etc.) In a slightly more complicated version of this assessment, the investigator may wish to inquire about a lifetime history of substance abuse or dependence, but exclude only those subjects who met criteria within the past year. It would then be necessary to go through all of the criteria, making the decision to EXCLUDE FROM STUDY only at the end of the Alcohol or Drug sections (e.g. items E21, E116, E117), after changing the definition of Current to correspond to the study definition (e.g. past year rather than past month).

3. Inclusion Criteria

A more complicated modification may be required for a study in which the goal is to screen in diagnoses during a specified period of time rather than for the past month, or for lifetime. For example, a drug study may have an inclusion criterion that requires a Major Depressive Episode with symptoms present during the past two weeks. The initial SCID questions for current Major Depressive Episode would have to be modified to inquire about the past two weeks rather than the past month. This change would also be reflected on the scoresheet.

The foregoing are examples of the most common ways in which the SCID might be modified. There are many other possibilities, and we suggest that an investigator who is considering a modification should consult with someone at SCID Central about how to customize the SCID. Brief telephone consultation is free (212-543-5524), but there will be a charge for investigators who need more extensive help in making major modifications.

4. Adding on to the SCID

Investigators may want to incorporate the collection of additional information into the SCID interview. For example, family history data that is to be coded may be collected during the overview with the addition of a few questions and items.

Rating scales, such as the Hamilton Depression Rating Scale, are sometimes inserted into the SCID. This process is more complicated than it may appear. It is necessary to pay attention to the time period being covered (usually past week for the Hamilton, and past month for the SCID depression criteria), and to make sure that the precise items in the scale, rather than the generally broader DSM-IV criteria, are being assessed. Investigators may want to discuss with a SCID expert the pros and cons of inserting a scale into the SCID or simply adding it to the end.....or the beginning....of a SCID interview.
5. Identifying your customized SCID

Anytime a SCID is modified, it should be identified as such on the cover page....e.g. "Modified for Use in the NIA Study of Late Life Depression, 9/95". In addition, a footer on each page should include this identification. The footer should also include consecutively numbered pages because it is easy to lose pages in the photocopying process, and to not realize they are missing until weeks, or months, later. Continuing with the example above, each page in the modified SCID should have a line across the bottom reading: NIA Late Life Depression - page 1....etc.

Another reason for including an identifying footer on each page is that students, teachers or other investigators will sometime pick up part of a SCID to reproduce, and it is important to identify that the severed SCID body part is not part of the standard SCID, and where it came from.

6. How much can you eliminate and still call it a SCID?

What differentiates the SCID from other instruments is a format that includes questions, diagnostic criteria and ratings. A very much-slimmed down SCID that still has those characteristics is probably eligible for membership in the SCID family. For example, a study in which subjects are carefully pre-screened for current Major Depressive Disorder may need to confirm the diagnosis with only the A and B/C and D modules, and all the subtypes eliminated. In another study, investigators may be interested only in assessing PTSD. If the cover page identifies nature of the modification (e.g. SCID-PTSD), we see no reason not to acknowledge it as a member of the family.
16. Appendix B: Training Materials

Two types of sample cases are included for training. The six role-play cases are useful for practicing how to administer the SCID. These role-play cases work best in groups of 2-4, with one person taking on the role of the SCID interviewer, a second person taking on the role of the subject, and the remaining participants acting as observers, making ratings along with the interviewer. Each case should be read by the “subject” only—the other members of the group should remain in the dark so that the psychopathology can be revealed as the role-play develops. The “subject” should start by reading the “overview” section aloud to the other members of the group. This is in lieu of doing the Overview, which we have found to be particularly difficult to role-play. The interviewer should begin the practice interview with the A module. The person playing the subject should follow the instructions about how to answer the questions so that multiple small groups doing the role-play in parallel will arrive at the same diagnosis. After each role-play case, it is suggested that the entire group discuss the case together, focusing on any discrepancies between groups. Sample pages of the relevant SCID modules demonstrating correct ratings are included following certain cases. For Depressed Truck Driver, we have included the Scoresheet (Mood Disorders only), Overview, and Modules A and D. For Weather Woman, we have included the Scoresheet (Mood Disorders only) and Modules A, B, C, and D. For Thunderstorms, the Scoresheet (Anxiety Disorders only) and Module F. For Drug Store, the Scoresheet (Substance Use Disorders only) and Module E. Pages on which there are no ratings have not been included.

The next seven homework cases (reprinted from the DSM-IV Casebook (Spitzer, Gibbon, Skodol, Williams, and First, 1994) with a few changes in some cases to make it easier to apply the diagnostic criteria) are intended to help the interviewer practice how to navigate through the C module of the SCID. When administering the SCID, the interviewer is expected to go through the C module with the subject sitting in front of him or her, so that the interviewer has the opportunity to ask additional clarifying questions. It is therefore advisable for the interviewer to become proficient in using the C module. Each case should be read and then “coded” as if one were administering the SCID to that subject, starting at the beginning of the A module. If information for rating a particular criterion is not mentioned in the case vignette, assume that it has not been present and assign a rating of 1. The discussion following each case indicates the correct “pathway” through the SCID, given the ratings in the case.
Role Play - Case #1

“Depressed Truck Driver”

OVERVIEW: (Read this aloud to the interviewer) This is a 60 year old truck driver who reports having been depressed for the past six months and has been unable to go to work. He also reports that he has been avoiding his friends and no longer likes to venture out of the house. He had a similar episode 10 years ago. Between these episodes he has felt well.

MOOD SYMPTOMS: Acknowledge persistent depression (criterion A[1]), loss of interest (criterion A[2]), 20 lb weight loss accompanied by loss of appetite (criterion A[3]), insomnia (criterion A[4]), psychomotor retardation (criterion A[5]), fatigue or loss of energy (criterion A[6], and guilt (criterion A[7]), but do not give details unless the interviewer asks for them. (Alternatively, you can demonstrate the severe psychomotor retardation if your acting skills are up to it). If asked, give enough concrete information to substantiate that symptoms have been present most of the day, nearly every day, for months. Deny psychomotor agitation (first half of criterion A[5]), feelings of worthlessness (first half of criterion A[7]), difficulty concentrating or making decisions (criterion A[8]), and suicidal ideation (criterion A[9]). When asked about guilt, say that you are feeling very guilty and provide an example that is clearly excessive; i.e., explain that your son has a serious drug problem, and you are convinced that it’s because you were on the road so much and didn’t spend time playing catch with him when he was a little boy. You are in good health and have not started using (nor increased the amount of) alcohol, drugs, or medications. This depression did not begin after someone close to you died.

For the questions about “With Melancholic Features,” clarify that the worst period of depression is the current period. Answer “yes” if the interviewer confirms that you have lost pleasure in all activities and that nothing gives you pleasure (although the interviewer may not ask this question). Say that even if something good happens or if your wife tries to cheer you up, you do not feel better at all--nothing can get you out of your down mood. Answer “yes” to the question about whether your mood is different from the kind of feeling you might get if someone died, “yes” that you feel regularly worse in the morning, and “yes” that you wake up every morning at 3 AM and cannot fall back asleep. If asked, confirm that you have been moving very slowly, that you have lost your appetite and been eating virtually nothing, and that you have been feeling very guilty (although the interviewer may not necessarily ask you these questions).

The next question to you should be about whether you have been manic in the last month. Answer “no” to the question about elevated mood but answer “yes” to the question about whether during the current month you have been shouting at people or starting fights or arguments--elaborate by reporting that all of the arguments have been confined to fighting with your wife about not wanting to go
out of the house. The interviewer should (hopefully) skip to the question about past manic episode. Deny that there have ever been any past episodes of elevated or irritable mood, and deny that you have been feeling down for more days than not in the past two years.

**PSYCHOTIC AND ASSOCIATED SYMPTOMS:** Answer “No” to everything except the first question about whether people pay special attention to you. In response to that, say that you stay inside because if you go on the street people keep asking why you’re not at work.

**SUBSTANCE USE DISORDERS:** You drink no more than 2 beers on an occasion, and that only rarely, and you’ve never used illegal drugs nor had any problem with prescribed drugs.

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**SCID Diagnosis:**

Major Depressive Disorder, Severe, Without Psychotic Features, With Melancholic Features.

**GAF:** 35  [major impairment in several areas]
Role Play - Case #2

“The Weather Woman”

OVERVIEW: (Read this aloud to the interviewer) A 50 year old woman is brought to the hospital by her family because she has not been sleeping, and her behavior has been increasingly bizarre over the past three weeks. She is very angry about her hospitalization, believing that her family just wants to prevent her from getting her good news to the world.

MOOD SYMPTOMS: Answer “never” to all questions about depression and loss of interest. In response to the question about elated mood, explain that you are feeling “joyous” about your newly discovered ability to control the weather. About “special powers” (criterion B[1]), explain that you have been granted the ability to control the weather and thereby end drought, disperse smog, reverse the greenhouse effect, and turn the world into Eden.

About your sleeping (criterion B[2]), say that you have not slept for ten days because you are so excited about your new powers. About talking too much (criterion B[3]), either demonstrate overtalkativeness, or tell the interviewer that your family is complaining that you talk too much. In response to the question about racing thoughts (criterion B[4]), say your mind is “flooded” with ideas about your new project. In answer to distractibility (criterion B[5]), say yes, but don’t give any examples. About increase in activities (criterion B[6]), say you have been going all over town to TV and radio stations to try to get the news out. About doing anything that could get you in trouble (criterion B[7]), say that you got arrested when you tried to get in to see Mike Wallace.

You are and have always been in excellent health and you deny having any alcohol or drugs of any kind for the past several years.

PSYCHOTIC SYMPTOMS: Answer “no” to people talking about you or taking special notice of you. In response to receiving special messages from the TV, explain that it’s your message you’ve been trying to get to the TV people.

About persecutory delusions, say your family thinks you’re crazy because they fail to understand the importance of your new powers, and you’re very angry with them for railroading you into the hospital. In response to questions about grandiose delusions, explain how you’ve had this revelation from “the deities” about how to control the weather. “No” to all other specific questions about delusions. When asked how you explain your ability to control the weather, say “don’t ask me, ask them!”

In response to questions about whether you hear voices, explain that these “deities” are not really voices, but that you awoke one morning with the
knowledge about how to control the weather and then understood that it had come from "the deities". In fact, you do not hear actual voices at all. Say "no" to all other hallucinations.

**SUBSTANCE USE DISORDERS:** You report having tried marijuana once and didn't like it and that you have never liked alcohol.

**SCID Diagnosis:**

Bipolar I Disorder, Manic, Severe With Psychotic Features

**GAF: 21** [behavior is considerably influenced by delusions and has gotten her into trouble]
Role Play - Case #3

“Guy From the FBI”

OVERVIEW: (Read this to the interviewer) This is a 35 year old female secretary who says she has been “pursued” by a federal agent ever since she appeared in court for a speeding ticket 10 years ago.

MOOD SYMPTOMS: In response to question about depression, say your mood is “distraught” and “upset,” and you've felt that way for weeks. Answer “no” to all the depressive symptom questions except for having trouble falling asleep, and trouble concentrating, because you are so frightened about what the FBI agent means to do.

Answer “no” to all manic questions. In response to the initial question for Dysthymic Disorder (page A.38), say that, while the court appearance occurred 10 years ago, it’s only in the last few weeks that you’ve realized he is stalking you and have been so upset. Therefore, you have not been depressed more days than not in the past two years.

PSYCHOTIC SYMPTOMS: In response to the initial question, explain that he is the only one who is paying special attention to you. You know this because you see him hanging around outside your building at night. And you get hang-ups on your answering machine that you’re sure are from him. In response to the question about persecutory delusions, say you’re not sure what he wants from you, but you think it’s something sexual.

Answer “no” to all other delusions.

Answer “no” to all hallucinations. If the interviewer pushes about visual hallucinations, explain that you have seen him night after night, hanging around your street, dressed in a beige raincoat and a baseball cap. He is not close enough to see his features, but you are sure it is him.

You have no medical problems and deny any drug or alcohol use and you are not taking any medications.

SCID Diagnosis:

Delusional Disorder, Moderate

GAF: 29 [behavior is influenced by delusions but less so than in previous case]
Role Play - Case # 4

“Junior Executive”

OVERVIEW: (Read this to the interviewer) A 28 year old, female junior executive, is referred for psychotherapy by her family doctor. She complained to him of being “depressed about everything”--her job, her husband, and her prospects for the future.

MOOD SYMPTOMS: In response to the initial question about depressed mood, say you’ve been depressed almost as long as you can remember--at least since high school. To loss of interest or pleasure, say you get very little pleasure out of anything you do. Insist that this is nearly every day. When asked about appetite (criterion A[2]), say that when you’re feeling really bad, you eat all day. If the interviewer asks if it’s nearly every day, say “no, maybe 2 or 3 days a week in the last month.” Say “no” to sleep problems or sleeping too much (criterion A[4]) and to psychomotor agitation or retardation (criterion A[5]). In response to the energy question (criterion A[6]), say you feel tired all the time. To how you feel about yourself (criterion A[7]), say you’re disappointed about not being promoted, even though you don’t really like your job....but deny worthlessness or guilt. Say “no” to poor concentration (criterion A[8]) and suicide thoughts (criterion A[9]).

The interviewer will then ask if you’ve had another time when you were depressed most of the day nearly every day. Patiently explain that you’ve already said that’s the way you always are, and hope that the interviewer will ask if you’ve had a time when it was much worse, and when you had more of the symptoms you were just asked about....to which you answer “no.”

Answer no to all the manic questions.

The interviewer will then ask you about the past two years. If he or she has been listening, this will hopefully be just a confirming question, such as “It sounds like you’ve been bothered by depressed mood more days than not in the past two years”, to which you answer “yes.”

Answer yes to overeating, low energy, low self-esteem, and feelings of hopelessness.

In response to what’s the longest time you’ve felt okay, say never more than a week or two.

No medical illness or substance use.

PSYCHOTIC SYMPTOMS: Say “no” to everything.
SCID Diagnosis:

Dysthymic Disorder

GAF: 58 (moderate symptoms--depressed mood, fatigue, anhedonia, overeating)
Role Play - Case #5

“Thunderstorms”

OVERVIEW: (Read this to the interviewer). This 28-year-old mother of two small children seeks treatment for a fear of thunderstorms that has become progressively more disturbing to her. She has been frightened of thunderstorms since she was a child, but it is much worse over the past few years. She is afraid she will pass it on to her children.

MOOD SYMPTOMS: Answer “no” to all the questions about persistent mood symptoms.... you’ve never been depressed for more than a day or two at a time, never been elated or irritable, and have not been depressed more days than not in the last two years.

PSYCHOTIC SYMPTOMS: Answer “no” to everything.

SUBSTANCE USE DISORDERS: You may occasionally drink a glass of wine with dinner when you go out; but alcohol never caused any problems. You tried marijuana once in college, but it just made you sleepy.

ANXIETY DISORDERS: Answer “yes” to the initial panic attack question. If the interviewer follows up with the question about “unexpected attacks”, explain that the panic attacks only happen during the height of a thunderstorm. Answer “Yes” to the question that you are afraid of going out of the house alone (page F.7) but make it clear that this is only during thunderstorms. Answer “Yes” to the question about whether you are afraid to do things in front of other people (page F.11) but explains that this is limited being nervous about speaking in front of large groups of people. When asked whether you’re more afraid than most people, say “no.”

In response to the initial question for specific phobia (page F.16), explain that you are afraid of thunderstorms because of the lightening and thunder. You’re afraid that the lightening may strike a tree, causing it to fall across your driveway and trap you at home.

In response to “do you always feel frightened,” explain that you start to worry whenever a storm is predicted, and have sometimes taken the kids to stay overnight with a relative if your husband is away when a storm is forecast. When it actually starts thundering and lightening, you run around the house closing curtains, and take the kids to the basement playroom until the storm is over.

You recognize that your behavior is excessive. It doesn’t really interfere with your life that much, but you’re upset about not being able to control the fear
because you can see your kids picking it up from you, which is why you came for treatment.

For the chronology section (page F.19), explain that there was a real bad storm in the past month and that you were very frightened at the time.

Answer “no” to obsessions but “yes” to compulsions. What you have to do is go back in the house almost every time you leave to check that the stove is off, the iron turned off, the electric heater unplugged, etc. This behavior is ritualized in that it must be done in a certain order or else you have to start all over again. This checking behavior ends up taking only about 5 or ten minutes a day and you insist that you are NOT bothered by it nor that it significantly interferes with your life.

Answer “no” to questions about PTSD, but “yes” to the screening question for GAD:.....that you have been particularly nervous or anxious, and worrying a lot about bad things that might happen and that this worry has been going on for the past 10 years. When the interviewer asks what you worry about, explain that you worry about everything--will your husband get to work safely every morning, will you have enough money to pay for the children’s education (your husband is an investment banker with a 6 figure income), whether your (healthy) parents will get sick, whether you'll be able to find your way to an appointment in a neighboring town, etc. Whenever you aren’t doing something that requires your attention, you are worrying about something.

In response to “do you find it’s hard to stop yourself?” answer that you often tell yourself it’s ridiculous to be worrying, but your mind keeps drifting back to whatever you’ve been worrying about.

In response to the symptom questions, answer that because of your “nerves,” you often feel on edge, feel tired a lot of the time, and have trouble getting to sleep because you think about all the things that might go wrong.

In response to what effect this has on your life, answer that you have to call your husband every day to make sure he got to work, and he finds this very annoying. You are also very critical of yourself for being this way, and wish you could loosen up.

There are no medical problems.
SCID Diagnoses:

Specific Phobia, Natural Environment Type, Mild Generalized Anxiety Disorder

GAF: 53 (anxiety, moderate compulsive rituals)
Role Play Case #6

“Drug Store”

OVERVIEW: (Read this aloud to the interviewer) This 40 year old swimming pool contractor who lives alone is interviewed in a community study. He has never been in treatment. He is currently in the midst of his busy season, working 60 hours a week, and spending evenings at the hospital visiting his terminally ill mother.

MOOD SYMPTOMS: Answer “yes” to the depression question, but when the interviewer asks about “most of the day, nearly every day”, say “no,” you are depressed about your mother, but you don’t think about it during the day because you’re so busy. In response to loss of interest, say you don’t have time to do anything but work, visit your mother and sleep. If the interviewer (incorrectly) asks the current depressive episode questions, answer “no” to all of them. Answer “no” to all other screening questions in the mood module.

PSYCHOTIC SYMPTOMS: Answer “no” to everything, except for vivid brightly colored “auras” (visual illusions--NOT hallucinations) when you were high on LSD.

SUBSTANCE USE DISORDERS: In response to “more than 5 drinks?” say you probably have, but not often. You usually drink two glasses of wine with dinner, or 3-4 beers during a social evening. The interviewer should then ask you about alcohol abuse, and you should say no to all the questions.

Note: This role-play is designed for the standard version of the E module. If you are using the alternative format, you should clarify that cocaine is the drug used most often and you will have to extract the cocaine history from the paragraph on the next page; essentially the following criteria for Cocaine Dependence have been present: criteria 3,4,5,7,1, and 2.

About drugs, here is your history of pattern of use in response to the questions on pages E.10 and E.11 referring you to the “drug list.” Between ages 25 and 35 you used drugs almost daily in the following pattern:

1) You smoked **marijuana** every day, 3 or 4 joints, sometimes beginning right after breakfast.

2) When it was available, sometimes for months at a time (because you were dealing it), you snorted **cocaine** daily.

3) You used **Quaaludes** when you were with a girlfriend who had a supplier, more than 10 times in a month, because they were great for sex.
4) Less than 10 times a month, you have also used **amphetamines** (when you had to drive long distances and needed to stay awake).

5) **Hallucinogens**: LSD maybe 20 times over the 10 years, and mescaline and “mushrooms” occasionally. Marijuana and cocaine were your “main” drugs and each of the others were used under particular circumstances—there was never a period of time when these drugs were used indiscriminately (i.e., no polysubstance dependence).

The interviewer should ask you all of the Substance Dependence questions for Quaaludes, marijuana and cocaine, since each of these drug groups was used more than 10 times per month. Answer “no” to the first question (criterion 3--use of larger amount than intended) regarding you use of marijuana and Quaaludes, but “yes” about cocaine (say that you often used up all your cocaine in one evening, even when you had an amount that should last for a week). Also answer “yes” to the second question (criterion 4--persistent desire or several attempts to quit) in regard to your cocaine use only (you tried to stop many times, but succeeded only when you moved to a place where it was not easy to get). To question #3 (criterion 5--a lot of time spent), ask the interviewer what he or she means by “a lot of time,” then say you were often “coked up” at work, and there were weeks when you were stoned on marijuana all day every day but “no” for Quaaludes. For criterion 6 (activities given up), answer “no” for all three drug classes. For criterion 7 (continued use despite knowledge of problem), no for marijuana and Quaaludes, but the coke made you very paranoid at work, and you kept using it anyway. For criterion 1 (tolerance), you needed to escalate the amount of cocaine you used, but not the marijuana or Quaaludes. Finally, (criterion 2) you did not have withdrawal symptoms from marijuana or Quaaludes, but when you finally quit cocaine you were irritable, exhausted and had trouble sleeping for weeks.

Now the interviewer should go on to the Substance Abuse questions for the hallucinogens and amphetamines (use less than ten times per month), but the questions should also be asked for Quaaludes and marijuana, since the criteria were not met for Substance Dependence for these drugs. For criterion 1 (failure to fulfill role obligations), say that you never used Quaaludes, hallucinogens, or amphetamines at work. Say that you often smoked marijuana all day long while at work, but insist that it never interfered with your functioning (you were servicing swimming pools). For criterion 2 (use when hazardous), answer “no” for Quaaludes and hallucinogens, but say you often drove when you were stoned on marijuana, and that you think it was just dumb luck that kept you from having an accident and that you used amphetamines for driving, but they helped you stay awake and never impaired your driving. Answer “no” for the remaining two abuse questions for all four drug classes.
**SCID Diagnoses:**
- Cocaine Dependence, In Full Remission
- Cannabis Abuse

**GAF:** 75 (depression in response to mother's illness)
Homework Case #1

“Low Life Level”

Louise Larkin is a pale, stooped woman of 39 years, whose childlike face is surrounded by scraggly blond braids tied with pink ribbons. She was referred for a psychiatric evaluation for possible hospitalization by her family doctor who was concerned about her low level of functioning. Her only complaint to him was: "I have a decline in self-care and a low life level." Her mother reports that there has indeed been a decline, but that it has been over many years. In the last few months she has remained in her room, mute and still.

Twelve years ago Louise was a supervisor in the occupational therapy department of a large hospital, living in her own apartment, and was engaged to a young man. He broke the engagement, and she became increasingly disorganized, wandering aimlessly in the street, wearing mismatched clothing. She was fired from her job, and eventually the police were called to hospitalize her. They broke into her apartment, which was in shambles, filled with papers, food and broken objects. No information is available from this hospitalization, which lasted three months, and from which she was discharged to her mother’s house with a prescription for unknown medication that she never had filled.

After her discharge her family hoped that she would gather herself together and embark again on a real life, but as the years progressed she became more withdrawn and less functional. Most of her time was spent watching TV and cooking. Her cooking consisted of mixing bizarre combinations of ingredients, such as broccoli and cake mix, cooking and eating them alone, because no one else in the family would eat her meals. She collected cookbooks and recipes, cluttering her room with stacks of these. Often when her mother entered her room, she would quickly grab a magazine and pretend to be reading, when in fact she had apparently just been sitting and staring into space. She stopped bathing and brushing her hair or teeth. She ate less and less, although she denied loss of appetite, and over a period of several years lost 20 pounds. She would sleep at odd hours. Eventually she became enuretic, wetting her bed frequently and filling the room with the pungent odor of urine.

On admission to the psychiatric hospital she sat with her hands tightly clasped in her lap, and avoided looking at the doctor who interviewed her. She answered questions readily and did not appear suspicious or guarded but her affect was shallow. She denied depressed mood, delusions or hallucinations. However, her answers became increasingly idiosyncratic and irrelevant as the interview progressed. In response to a question about her strange cooking habits, she replied that she did not wish to discuss recent events in Russia. When discussing her decline in functioning, she said, "There's more of a take-off mechanism when you're younger." Asked about ideas of reference, she said, "I doubt it's true, but if one knows the writers involved, it could be an element that would be directed in a comical way." Her answers were interspersed with the mantra, "I'm safe. I'm safe."
SCID Coding for “Low Life Level”

Module A:

Page A.1: A1=1; A2=1
Page A.12: A52=1, A53=1
Page A.18: A83=1
Page A.28: A126=1
Page A.38: A163=1

Module B:

Page B.1: B1=1; B2=1; B3=1
Page B.2: B4=1; B5=1
Page B.3: B11=1; B14=1, B15=1
Page B.4: B16=1; B19=1; B20=1; B21=1;
Page B.5: B24-B28=1
  B29=3 (Disorganized behavior - “she became increasingly disorganized, wandering aimlessly in the street, wearing mismatched clothing”)
Page B.6: B30=1;
  B31=3 (Disorganized speech - "answers became increasingly idiosyncratic and irrelevant"...."I doubt it's true, but if one knows the writers involved, it could be an element that would be directed in a comical way")
Page B.7: B32=3/B33=3: (Avolition - "sitting and staring into space"...."stopped brushing her hair or teeth")
  B34=1
  B36=2 (Affective flattening - “her affect was shallow”)

Module C:

Page C.1: C1 is not checked; C2=3 (psychotic sxs outside of Mood Episodes)
Page C.2: C3=3 (disorganized speech and negative symptoms occurring together for at least a month)
Page C.3: C4=3 (no mood episode ever)
Page C.4: C6=3 (continuous signs of illness for years)
  C7=3 (severe functional impairment)
Page C.5: C8=3 (not due to substance or general medical condition)
Page C.6: C9=1; C10=1
Page C.7: C11=1 (no flat or inappropriate affect)
       C12=3 (Undifferentiated Type)
Page C.8: C13a=3 (symptoms present last month)
       C13b=3 (severe)
Page C.9: C13e: 27 (age at onset)
       C13f: 99
       C13g: 27 (onset of prodromal symptoms)

SCID Dx: SCHIZOPHRENIA, UNDIFFERENTIATED TYPE

GAF: 15 (occasionally fails to maintain personal hygiene)
Homework Case #2

"I Am Vishnu"

Mr. Nehru is a 32-year-old, single, unemployed man who migrated from India to the United States when he was 13. His brother brought him to the emergency room of an Atlanta, Georgia, hospital after neighbors complained that he was standing in the street harassing people about his religious beliefs. To the psychiatrist he keeps repeating, ``I am Vishnu. I am Krishna.''

Mr. Nehru has been living with his brother and sister-in-law for the past seven months, attending an outpatient clinic. During the last four weeks, his behavior has become increasingly disruptive. He awakens his brother at all hours of the night to discuss religious matters. He often seems to be responding to voices that only he hears. He neither bathes nor changes his clothes.

Mr. Nehru's first episode of emotional disturbance was five years ago. Medical records are not available; but from the brother's account, it seems to have been similar to the present episode. There have been two other similar episodes, each requiring hospitalization for a few months. Mr. Nehru admits that, starting about five years ago and virtually continuously since then, he has been troubled by ``voices'' that he hears throughout the day. There are several voices, which comment on his behavior and discuss him in the third person. They usually are either benign (``Look at him now. He is about to eat.'') or insulting in content (``What a fool he is. He doesn't understand anything!'').

Between episodes, according to both his outpatient psychiatrist and his brother, Mr. Nehru is a quiet, somewhat withdrawn person, but popular in his neighborhood because he helps some of his elderly neighbors with shopping and yard work. At these times his mood is unremarkable. However, he claims that because of the ``voices,'' he cannot concentrate sufficiently to hold a job. He sometimes reads books, but watches little TV, because he hears the voices coming out of the television and is upset that the television shows often refer to him.

For the past six weeks, with increasing insistence, the voices have been telling Mr. Nehru that he is the new Messiah, Jesus, Moses, Vishnu, and Krishna, and should begin a new religious epoch in human history. He has begun to experience surges of increased energy, ``so I could spread my gospel,'' and needs very little sleep. According to his brother, he has become more preoccupied with the voices and disorganized in his daily activities.

When interviewed, Mr. Nehru is euphoric, and his speech is rapid and hard to follow. He paces up and down the ward and, upon seeing a doctor, grabs his arm, puts his face within two inches of the doctor's, and talks with great rapidity and enthusiasm about his religious ``insights.'' In the middle of a speech on his new religion, he abruptly compliments the doctor on how well his shirt and tie match. When limits are placed on his behavior, he becomes loud and angry. In addition to his belief that he is the Messiah, he feels that the hospital is part of a conspiracy to suppress his religious message. Although he seems to enjoy his ``voices,'' he sometimes complains about them and makes references to ``those
damned voices.” He states that he feels that his religious insights, euphoria, and energy have been put into him by God.
SCID Coding for “I Am Vishnu”

Module A:

Page A.1: A1=1; A2=1
Page A.12: A52=1; A53=1
Page A.18: A83=3 (“Mr. Nehru is euphoric”)
         A84 and A85 both checked (euphoric and irritable)
         A86=3 (hospitalized)
Page A.19: A87=3 (“he is the new Messiah”)
         A88=3 (“needs very little sleep”)
         A89=3 (“talks with great rapidity and enthusiasm”)
         A90=3 (“speech is rapid and hard to follow”)
         A91=3 (“In the middle of a speech on his new religion, he
                abruptly compliments the doctor on how well his
                shirt and tie match”)
         A92=3 (“He paces up and down the ward”)
         A93 and A94 both checked
Page A.20: A95=1; A96=3; A97=3 (hospitalized)
Page A.21: A98=3 (not due to GMC/Substance)
         A99=3 (Current Manic Episode)
Page A.22: A100=03
         A101=1; A102=1; A103=1
Page A.23: A104-A107=1
Page A.24: Criteria are met for Manic Episode -- item checked; go to next
         module.

Module B:

Page B.1: B1=3 (“the TV shows often refer to him”)
         B2=3 (“the hospital is part of a conspiracy to suppress his religious
         message”)
         B3=3 (“he is the new Messiah”)
Page B.2: B4=1; B5=3 and B6 is checked (religious delusions)
Page B.3: B11, B14 and B15=1
Page B.4: B16=3 (“troubled by voices that he hears throughout the day”)
         B17=3 (“ several voices commenting on his behavior”)
         B18=3 (“.....and discuss him in the third person” -- implies they are
                conversing with each other)
         B19, B20 and B21=1
Pages B.5 through B.7: all items = 1
Module C:

Page C.1:  C1 not checked; C2=3 (Psychotic symptoms when not manic-voices for 5 years)
Page C.2:  C3=3 (delusions and hallucinations)
Page C.3:  C4=1 (there ARE manic symptoms concurrent with active phase symptoms of Schizophrenia)
C5=1 (total duration of the manic symptoms has NOT been brief relative to total duration of illness; manic symptoms accompany each exacerbation)
Page C.13: C22=3 (manic symptoms concurrent with active symptoms of Schizophrenia)
C23=3 (auditory hallucinations in the absence of prominent mood symptoms)
C24=3 (Mood episode symptoms for a substantial portion of the duration of the illness)
Page C.14: C25=3 (Not due to GMC/Substance)
C26=3 (Bipolar type)
Page C.24: C51=3 (met criteria during past month)
C52=3 (psychotic symptoms persistent and markedly influence behavior)
Page C.25: C55=27 (age at onset)
C56=03 (exacerbations)

SCID DX: SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE

GAF: 17 (occasionally fails to maintain personal hygiene--“neither bathes nor changes his clothes”)
Homework Case #3

"Contract On My Life"

Mr. Polsen, a 42-year-old married African-American postal worker and father of two, is brought to the emergency room by his wife because he has been insisting that "there is a contract out on my life."

According to Mr. Polsen, his problems began four months ago when his supervisor at work accused him of tampering with a package. Mr. Polsen denied that this was true and, because his job was in jeopardy, filed a protest. At a formal hearing, he was exonerated and, according to him, "This made my boss furious. He felt he had been publicly humiliated."

About two weeks later, Mr. Polsen noticed that his co-workers were avoiding him. "When I'd walk toward them, they'd just turn away like they didn't want to see me." Shortly thereafter, he began to feel that they were talking about him at work. He never could make out clearly what they were saying, but he gradually became convinced that they were avoiding him because his boss had taken out a contract on his life.

This state of affairs was stable for about two months, until Mr. Polsen began noticing several "large white cars," new to his neighborhood, driving up and down the street on which he lived. He became increasingly frightened and was convinced that the "hit men" were in these cars. He refused to go out of his apartment without an escort. Several times, when he saw the white cars, he would panic and run home. After one such incident, his wife finally insisted that he accompany her to the emergency room.

Mr. Polsen was described by his wife and brother as a basically well-adjusted, outgoing man who enjoyed being with his family. He had served with distinction in Vietnam. He saw little combat there, but was pulled from a burning truck by a buddy seconds before the truck blew up.

When interviewed, Mr. Polsen was obviously frightened. Aside from his belief that he was in danger of being killed, his speech, behavior, and demeanor were in no way odd or strange. His predominant mood was anxious. He denied having hallucinations and all other psychotic symptoms except those noted above. He claimed not to be depressed; and although he noted that he had recently had some difficulty falling asleep, he said there had been no change in his appetite, sex drive, energy level, or concentration.


**SCID Coding for “Contract on my Life”**

**Module A:**

- **Page A.1:** A1=1; A2=1
- **Page A.12:** A52=1; A53=1
- **Page A.18:** A83=1
- **Page A.28:** A126=1
- **Page A.38:** A163=1

**Module B:**

- **Page B.1:** B1=3 ("hit men" in white cars; co-workers turning away)
  B2=3 (boss put out a contract on his life)
  B3=1
- **Page B.2:** B4-B5=1
- **Page B.3:** B11-B15=1
- **Page B.4:** B16-B21=1
- **Page B.5:**
- **Page B.7:** B22-B37=1

**Module C:**

- **Page C.1:** C1 not checked; C2=3 (no mood episode ever)
- **Page C.2:** C3=1 (no hallucinations, disorganized speech or behavior or negative symptoms)
- **Page C.15:** C27=3 (no mood episode ever)
- **Page C.16:** C30=3 (nonbizarre delusion)
  C31=3 (never met criteria for Schizophrenia)
  C32=3 (apart from impact of delusion functioning not markedly impaired; no odd or bizarre behavior)
  C33=3 (not due to GMC/Substance)
- **Page C.17:** C34=1 (Persecutory delusion)
- **Page C.24:** C51=3 (met criteria during past month)
  C52=3 (psychotic symptoms persistent and markedly influence behavior)
- **Page C.25:** C55=42
  C56=01 (only one episode)

**SCID DX: DELUSIONAL DISORDER, PERSECUTORY TYPE**

**GAF:** 27 (behavior is markedly influenced by delusions--will not go out of apartment without an escort)
Homework Case #4

“The Socialite”

Dorothea Cabot, a 42-year-old socialite, has never had any mental problems before. A new performance hall is to be formally opened with the world premiere of a new ballet; and Dorothea, because of her position on the cultural council, has assumed the responsibility for coordinating that event. However, construction problems, including strikes, have made it uncertain whether finishing details will meet the deadline. The set designer has been volatile, threatening to walk out on the project unless the materials meet his meticulous specifications. Dorothea has had to calm this volatile man while attempting to coax disputing groups to negotiate. She has also had increased responsibilities at home since her housekeeper has had to leave to visit a sick relative.

In the midst of these difficulties, her best friend has been decapitated in a tragic auto crash. Dorothea herself is an only child, and her best friend had been very close to her since grade school. People have often commented that the two women were like sisters.

Immediately following the funeral, Dorothea becomes increasingly tense and jittery, and able to sleep only two to three hours a night. Two days later she happens to see a woman driving a car just like the one her friend had driven. She is puzzled, and after a few hours she becomes convinced that her friend is alive, that the accident had been staged, along with the funeral, as part of a plot. Somehow the plot is directed toward deceiving her, and she senses that somehow she is in great danger and must solve the mystery to escape alive. She begins to distrust everyone except her husband, and begins to believe that the phone is tapped and that the rooms are "bugged." She pleads with her husband to help save her life. She begins to hear a high-pitched, undulating sound, which she fears is an ultrasound beam aimed at her. She is in a state of sheer panic, gripping her husband's arm in terror, as he brings her to the emergency room the next morning.
SCID Coding for “The Socialite”

Module A: (same as all the others)

Page A.1:  A1=1; A2=1
Page A.12: A52=1; A53=1
Page A.18: A83=1
Page A.28: A126=1
Page A.38: A163=1

Module B:

Page B.1:  B1=1
           B2=3 (plot to deceive her; phone is tapped; room is bugged; she is in danger)
           B3=1
Page B.2:  B4-B5=1
Page B.3:  B11-B15=1
Page B.4:  B16=3 (high-pitched “ultrasound”)  B17-B21=1
Page B.5-
Page B.8:  B22-B37=1

Module C:

Page C.1:  C1 is not checked; C2=3 (no Mood Episodes)
Page C.2:  C3=1 (both delusions and hallucinations but lasted less than one month)
Page C.15: C27=3 (no mood episodes)
Page C.16: C30=1 (non-bizarre, but for less than one month)
Page C.17: C35=3 (delusions and hallucinations)
Page C.18: C36=3 (not due to GMC/Substance)
           C37=3 (duration at least one day but less than one month)
Page C.24: C51=3 (current past month)
           C52=3 (severe)
Page C.25: C55=42 (age at onset)
           C56=01

SCID DX: BRIEF PSYCHOTIC DISORDER, WITH MARKED STRESSORS

GAF: 25 (behavior considerably influenced by delusions and hallucinations)
Homework Case #5

Under Surveillance

Mr. Simpson is a 44-year-old, single, unemployed, white man brought into the emergency room by the police for striking an elderly woman in his apartment building. His chief complaint is, "That damn bitch. She and the rest of them deserved more than that for what they put me through."

He has been continuously ill since the age of 22. During his first year of law school, he gradually became more and more convinced that his classmates were making fun of him. He noticed that they would snort and sneeze whenever he entered the classroom. When a girl he was dating broke off the relationship with him, he believed that she had been "replaced" by a look-alike. He called the police and asked for their help to solve the "kidnapping." His academic performance in school declined dramatically, and he was asked to leave and seek psychiatric care.

Mr. Simpson got a job as an investment counselor at a bank, which he held for seven months. However, he was getting an increasing number of distracting "signals" from co-workers, and he became more and more suspicious and withdrawn. It was at this time that he first reported hearing voices. He was eventually fired, and soon thereafter was hospitalized for the first time, at age 24. He has not worked since.

Mr. Simpson has been hospitalized 12 times, the longest stay being eight months. However, in the last five years he has been hospitalized only once, for three weeks. During the hospitalizations he has received various antipsychotic drugs. Although outpatient medication has been prescribed, he usually stops taking it shortly after leaving the hospital. Aside from twice-yearly lunch meetings with his uncle and his contacts with mental health workers, he is totally isolated socially. He lives on his own and manages his own financial affairs, including a modest inheritance. He reads the Wall Street Journal daily. He cooks and cleans for himself.

Mr. Simpson maintains that his apartment is the center of a large communication system that involves all three major television networks, his neighbors, and apparently hundreds of "actors" in his neighborhood. There are secret cameras in his apartment that carefully monitor all his activities. When he is watching TV, many of his minor actions (e.g., going to the bathroom) are soon directly commented on by the announcer. Whenever he goes outside, the "actors" have all been warned to keep him under surveillance. Everyone on the street watches him. His neighbors operate two different "machines": one is responsible for all of his voices, except the "joker." He is not certain who controls this voice, which "visits" him only occasionally, and is very funny. The other voices, which he hears many times each day, are generated by this machine, which he sometimes thinks is directly run by the neighbor whom he attacked. For example, when he is going over his investments, these "harassing" voices constantly tell him which stocks to buy. The other machine
he calls ``the dream machine.'' This machine puts erotic dreams into his head, usually of ``black women.''

Mr. Simpson describes other unusual experiences. For example, he recently went to a shoe store 30 miles from his house in the hope of getting some shoes that wouldn't be ``altered.'' However, he soon found out that, like the rest of the shoes he buys, special nails had been put into the bottom of the shoes to annoy him. He was amazed that his decision concerning which shoe store to go to must have been known to his ``harassers'' before he himself knew it, so that they had time to get the altered shoes made up especially for him. He realizes that great effort and ``millions of dollars'' are involved in keeping him under surveillance. He sometimes thinks this is all part of a large experiment to discover the secret of his ``superior intelligence.''

At the interview, Mr. Simpson is well-groomed, and his speech is coherent and goal-directed. His affect is, at most, only mildly blunted. He was initially very angry at being brought in by the police. After several weeks of treatment with an antipsychotic drug failed to control his psychotic symptoms, he was transferred to a long-stay facility with the plan to arrange a structured living situation for him.
**SCID coding for “Under Surveillance”**

**Module A:**

*Page A.1:* A1=1; A2=1  
*Page A.12:* A52 =1; A53=1  
*Page A.18:* A83=1  
*Page A.28:* A126=1  
*Page A.38:* A163=1

**Module B:**

*Page B.1:* B1=3 (TV comments on his behavior; everyone in the street watches him; shoes are “altered” to annoy him)  
B2=3 (machine-generated voices harass him)  
B3=3 (millions of dollars being spent, perhaps part of a large experiment to discover the secret of his superior intelligence)  
*Page B.2:* B4=1  
B5=3 (girlfriend “replaced” by a look-alike)  
*Page B.3:* B11=3 (machine puts erotic dreams of black women in his head)  
B14=1  
B15=3 (the “dream machine”)  
*Page B.4:* B16=3 (machine-generated harassing voices every day)  
B17=1 (TV announcer commenting on his minor actions does not appear to be voices)  
B18-B23=1  
*Page B.5:* B24-B29=1  
*Page B.6:* B30-B31=1  
*Page B.7:* B32-B37=1

**Module C:**

*Page C.1:* C1 not checked; C2=3 (no mood episode ever)  
*Page C.2:* C3=3 (delusions and hallucinations)  
*Page C.3:* C4=3 (no mood episode ever)  
*Page C.4:* C6=3 (continuous signs of illness for years)  
C7=3 (marked functional impairment)  
*Page C.5:* C8=3 (Not due to GMC/Substance)  
*Page C.6:* C9=3 (Preoccupied with delusions and hallucinations; no disorganized speech or behavior; no flat or inappropriate affect; no catatonic behavior)  
*Page C.8:* C13a=3 (symptoms present last month)  
C13b=3 (severe)  
*Page C.9:* C13e: 22 (age at onset)
C13f: 99
C13g: 22 (onset of prodromal symptoms)

SCID DX: SCHIZOPHRENIA, PARANOID TYPE

GAF: 20 (behavior considerably influenced by psychotic symptoms, and some danger to others--hit elderly woman)
Homework Case #6

“Agitated Businessman”

This agitated 42-year-old businessman was admitted to the psychiatric service after a two-and-one-half-month period in which he found himself becoming increasingly distrustful of others and suspicious of his business associates. He was taking their statements out of context, “twisting” their words, and making inappropriately hostile and accusatory comments; he had, in fact, lost several business deals that had been “virtually sealed.” Finally, the patient fired a shotgun into his backyard late one night when he heard noises that convinced him that intruders were about to break into his house and kill him.

One and one-half years previously, the patient had been diagnosed as having Narcolepsy because of daily irresistible sleep attacks and episodes of sudden loss of muscle tone when he got emotionally excited, and had been placed on an amphetaminelike stimulant, methylphenidate. He became asymptomatic and was able to work quite effectively as the sales manager of a small office-machine company and to participate in an active social life with his family and a small circle of friends.

In the four months before admission he had been using increasingly large doses of methylphenidate to maintain alertness late at night because of an increasing amount of work that could not be handled during the day. He reported that during this time he often could feel his heart race and had trouble sitting still.
SCID Coding for “Agitated Businessman”

Module A:

Page A.1:  A1=1; A2=1
Page A.12: A52=1, A53=1
Page A.18: A83=1
Page A.28: A126=1
Page A.38: A163=1

Module B:

Page B.1:  B1=3 (he heard noises that convinced him that intruders were about to break into his house and kill him)
           B2=2 (suspicious of business associates--not clear that he has a delusional conviction about any particular issue--remember to give the patient the benefit of the doubt when a psychotic symptom is not clearly present)
           B3=1

Pages B.2 through B.7 - all items coded 1

Module C:

Page C.1:  C1 is not checked; C2=3 (psychotic sx$s but no mood episodes)
Page C.2:  C3=1 (only a non-bizarre delusion of reference--Go to Page C.12)
Page C.15: C27=3 (no mood episodes)
Page C.16: C30=3 (non-bizarre delusion for 2 months)
           C31=3 (has not met criterion A for Schizophrenia)
           C32=3 (behavior not markedly impaired or bizarre)

The assessment of C33 requires that you first jump to C.16 to assess the etiology of the psychotic symptoms if there is a reasonable likelihood that the psychotic symptoms may be due to a substance or a general medical condition. In this case, both substance use (e.g., methylphenidate) and a general medical condition (e.g., Narcolepsy) are present, so both Psychotic Disorder Due to a General Medical Condition and Substance-Induced Psychotic Disorder should be considered.

Page C.19: The “if” statement should NOT be checked since the psychotic symptoms are temporally related to the Narcolepsy (i.e., they have their onset after the onset of Narcolepsy).

           C41=3 (delusion of reference)
C42=1 (there is no evidence that the delusion is the direct consequence of Narcolepsy; i.e., delusions are not known to result from Narcolepsy)

**Page C.21:**

C43=3 (delusion of reference)

C44=3 (symptoms developed after increasing use of methylphenidate)

C45=3 (not better accounted for by primary psychotic disorder, like Delusional Disorder since: 1) the psychotic symptoms did NOT precede the onset of the substance use; 2) the psychotic symptoms are NOT in excess of what you would expect given the amount of methylphenidate being used; and 3) there is no other evidence of an independent non-substance-induced psychotic disorder)

**Page C.22:**

C46=3 (Substance-Induced Psychotic Disorder; no evidence for delirium, i.e., no clouding of consciousness)

C47=1 (with delusions)

C48=1 (with onset during intoxication)

At this point, you are instructed to “Return to disorder being evaluated.” The box in the upper right hand corner of C.21 instructs you to turn the page to C.13 and resume with your rating of C33.

**Page C.16:**

C33=1 (Due to direct physiological effects of a substance)

Since all of these patient's psychotic symptoms are related to having taken amphetamines (i.e., there is no history of psychotic symptoms that are not due to a substance), you are instructed to go to the Chronology section, on C.24.

**Page C.24:**

C51=3 (symptoms in past month)

C52=3 (symptoms markedly influence behavior)

**Page C.25:**

C55=42

C56=01

**SCID DX: SUBSTANCE-INDUCED PSYCHOTIC DISORDER**

**GAF=22** (behavior considerably influenced by delusion--shooting at Imaginary intruders)
Homework Case #7

“Bad Voices”

Carmen Galvez is an attractive, 25-year-old, divorced, Dominican mother of two children. A redhead with a pouty and seductive demeanor, Ms. Galvez was referred to the psychiatric emergency room by a psychiatrist who was treating her in an anxiety disorders clinic. After telling her doctor that she heard voices telling her to kill herself, and then assuring him that she would not act on the voices, Ms. Galvez skipped her next appointment. Her doctor called her to say that if she did not voluntarily come to the emergency room for an evaluation, he would send the police for her.

Interviewed in the emergency room by a senior psychiatrist with a group of emergency room psychiatric residents, Ms. Galvez was at times angry and insistent that she did not like to talk about her problems, and that the psychiatrists would not believe her or help her anyway. This attitude alternated with flirtatious and seductive behavior.

Ms. Galvez first saw a psychiatrist seven years previously, after the birth of her first child. At that time, she began to hear a voice telling her that she was a bad person and that she should kill herself. She would not say exactly what it told her to do, but she reportedly drank nail polish remover in a suicide attempt. At that time, she remained in the emergency room for two days and received an unknown medication that reportedly helped quiet the voices. She did not return for an outpatient appointment after discharge, and continued having intermittent periods of auditory hallucinations at various points over the next seven years with some periods lasting for months at a time. For example, often when she was near a window, a voice would tell her to jump out, and when she walked near traffic, it would tell her to walk in front of a car.

She reports that she continued to function well after that first episode, finishing high school and raising her children. She was divorced a year ago, but refused to discuss her marital problems. About two months ago, she began to have trouble sleeping and felt "nervous". It was at this time that she responded to an ad for the anxiety clinic. She was evaluated and given Haldol, an antipsychotic. She claims that there was no change in the voices at that time, and only the insomnia and anxiety were new. She specifically denied depressed mood or anhedonia, or any change in her appetite, but did report that she was more tearful and lonely, and sometimes ruminated about "bad things", such as her father's attempted rape of her at age 14. Despite these symptoms, she continued working more than full time as a salesperson in a department store.

Ms. Galvez says she did not keep her follow-up appointment at the anxiety clinic because the Haldol was making her stiff and nauseous, as well as not helping her symptoms. She denies wanting to kill herself, and cited how hard she was working to raise her children as evidence that she would not "leave them that way." She did not understand why her behavior had alarmed her psychiatrist.
Ms. Galvez denied alcohol or drug use, and a toxicology screen for various drugs was negative. Physical examination and routine laboratory tests were also normal. She had stopped the Haldol on her own two days before the interview.

Following the interview, there was disagreement among the staff about whether to let the patient leave. It was finally decided to keep her overnight, until her mother could be seen the following day. When told she was to stay in the emergency room, she replied angrily, yet somewhat coyly: "Go ahead. You'll have to let me out sooner or later, but I don't have to talk to you if I don't want to." During the night, nursing staff noticed that she was tearful, but she said she didn't know why she was crying.

When the mother was interviewed the following morning, she said she did not see a recent change in her daughter. She did not feel that her daughter would hurt herself, but agreed to stay with her for a few days and make sure she went for follow-up appointments. In the family meeting, Carmen complained that her mother was unresponsive and did not help her enough. However, she again denied depression and said she enjoyed her job and her children. About the voices, she said that over time she had learned how to ignore them, and that they did not bother her as much as they had at first. She agreed to outpatient treatment provided the therapist was a female.
**SCID Coding for “Bad Voices”**

**Module A:**

*Page A.1:*  
A1=1 (denied depressed mood)  
A2=1 (denied anhedonia)  

*Page A.12:*  
A52=1 (no information on past persistent depressed mood)  
A53=1 (no information on past persistent anhedonia)  

*Page A.18:*  
A83=1 (no current elevated, expansive or irritable mood)  

*Page A.28:*  
A126=1 (no evidence of past “manic” mood)  

*Page A.38:*  
A163=1 (no evidence of chronic depressed mood)

**Module B:**

*Pages B.1, B.2, and B.3:* all items coded 1 (no delusions)  
*Page B.4:*  
B16=3 (voices telling her to kill herself)  
B17-B21=1  

*Pages B5 through B8:* all items coded 1

**Module C:**

*Page C.1:*  
C1 not checked; C2=3 (no documentation of mood episodes)  

*Page C.2:*  
C3=3 (hallucinations but not of a voice keeping up a running commentary or two or more voices conversing)  

*Page C.15:*  
C27=3 (no mood episodes)  

*Page C.16:*  
C30=1 (no delusions)  

*Page C.17:*  
C35=3 (hallucinations)  

*Page C.18:*  
C36=3 (not due to a substance or GMC)  
C37=1 (duration more than one month)  

*Page C.23:*  
C49=3 (psychotic symptoms, not meeting criteria for any specific psychotic disorder)  
C50=3 (persistent auditory hallucinations)  

*Page C.24:*  
C51=3 (present in current month)  
C52=2 (moderate)  

*Page C.25:*  
C55=18 (age at onset)  
C56=99

**SCID DX:** PSYCHOTIC DISORDER NOT OTHERWISE SPECIFIED  

**GAF:** 39 (some impairment in reality testing--intermittent hallucinations)
Homework Case #8

“Late Bloomer”

Ms. Fielding is a 35-year-old single, unemployed, college educated, African-American woman who was escorted to the emergency room by the mobile crisis team. The team had been contacted by the patient’s sister after she failed to persuade Ms. Fielding to visit an outpatient psychiatrist. Her sister was concerned about the patient’s increasingly erratic work patterns, and more recently, bizarre behavior, since the death of their father two years ago. The patient’s only prior psychiatric contact had been brief psychotherapy in college.

The patient had not worked since being laid off her job three months ago. According to her boyfriend and roommate (both of whom live with her), she became intensely preoccupied with the upstairs neighbors. A few days ago she banged on their front door with an iron for no apparent reason. She told the mobile crisis team that the family upstairs was harassing her by “accessing” her thoughts and then repeating them to her. The crisis team brought her to the emergency room for evaluation of “thought broadcasting.” Though she denied having any trouble with her thinking, she conceded that she was feeling “stressed” since losing her job, and might benefit from more psychotherapy.

After reading the admission note that described such bizarre symptoms, the emergency room psychiatrists were surprised to encounter a poised, relaxed and attractive young woman, stylishly dressed and appearing perfectly normal. She greeted them with a courteous, if somewhat superficial, smile. She related to the doctors with nonchalant respectfulness. When asked why she was there, she ventured a timid shrug, and replied, "I was hoping to find out from you!"

Ms. Fielding had been working as a secretary, and attributed her job loss to the sluggish economy. She said she was "stressed out" by her unemployment. She denied having any recent mood disturbance, and answered "no" to questions about psychotic symptoms, punctuating each query with a polite but incredulous laugh. Wondering if perhaps the crisis team’s assessment was of a different patient, the interviewer asked, somewhat apologetically, if the patient ever wondered whether people could read her mind. She replied, "Oh yes, it happens all the time", and described how, on one occasion, she was standing in her kitchen planning dinner in silence, only to hear, moments later, voices of people on the street below reciting the entire menu. She was convinced of the reality of the experience, having verified it by looking out the window and observing them speaking her thoughts aloud.

The patient was distressed not so much by people "accessing" her thoughts as by her inability to exercise control over the process. She believed that most people developed telepathic powers in childhood, while she was a "late bloomer" who had just become aware of her abilities, and was currently overwhelmed by them. Although she began having telepathic experiences two years ago, they had become almost constant in the three months since losing her job. She was troubled most by her upstairs neighbors, who would not only repeat her thoughts, but also bombard her with their own devaluing and critical
comments, such as "you're no good" and "you have to leave." They had begun to intrude upon her mercilessly, at all hours of the night and day.

She was convinced that the only solution was for the family to move away. When asked if she had contemplated other possibilities, she reluctantly admitted that she had spoken to her boyfriend about hiring a hit man to "threaten", or, if need be, "eliminate" the couple. She hoped she would be able to spare their two children, whom she felt were not involved in this invasion of her "mental boundaries." This concern for the children was the only insight she demonstrated into the gravity of her symptoms. She did agree, however, to admit herself voluntarily to the hospital.
**SCID Coding for “Late Bloomer”**

**Module A:**

*Page A.1:* \[A1=1; A2=1\]

*Page A.12:* \[A52=1, A53=1\]

*Page A.18:* \[A83=1\]

*Page A.28:* \[A126=1\]

*Page A.38:* \[A163=1\]

**Module B:**

*Page B.1:* B1=3 (observed people on the street speaking her thoughts aloud)

B2=3 (neighbors are “harassing” her)

B3=1 (her “telepathic” powers are not grandiose in content)

*Page B.2:* B4 and B5=1

*Page B.3:* B11=1

B14=3 (neighbors “accessing” her thoughts; hearing people on the street repeating what she has thought)

B15=3 (see above)

*Page B.4:* B16=3 (neighbors “bombard her with their own devaluing and critical comments”)

B17 through B21=1

*Pages B.5 through B.7* - all items coded 1

**Module C:**

*Page C.1:* C1 not checked; C2=3 (no mood episodes)

*Page C.2:* C3=3 (delusions and hallucinations)

*Page C.3:* C4=3 (no mood episodes)

*Page C.4:* C6=1 (psychotic symptoms for only 3 months--giving her the benefit of the doubt that the “telepathic experiences” over two years are simply her retrospective re-interpretation of events as a result of her current psychotic state)

*Page C.11:* C14=3 (psychotic symptoms for 3 months)

C15=3 (NOT due to GMC/Substance)

C16=2 (not yet recovered)

*Page C.12:* C17=3 (acute onset)

C18=1 (no confusion or perplexity)

C19=3 (good premorbid functioning)

C20=3 (no blunted or flat affect)

C21=3 (with good prognostic features)

*Page C.24:* C51=3 (meets criteria past month)

C52=2 (moderate)
Page C.25:  C55=35 (age at onset)
            C56=01 (number of episodes)

SCID DX: SCHIZOPHRENIFORM DISORDER, MODERATE, WITH GOOD PROGNOSTIC FEATURES

GAF: 23 (behavior considerably influenced by delusions)
Homework Case #9

Radar Messages

Alice Davis, a 24-year-old copy editor who has recently moved from Colorado to New York, comes to a psychiatrist for help in continuing her treatment with a mood stabilizer, lithium. She describes how, three years previously, she was a successful college student in her senior year, doing well academically and enjoying a large circle of friends of both sexes. In the midst of an uneventful period in the first semester, she began to feel depressed; experienced loss of appetite, with a weight loss of about ten pounds; had both trouble falling asleep and waking up too early; had severe fatigue, felt worthless, and had great difficulty concentrating on her school work.

After about two months of these problems, they seemed to go away; but she then began to feel increasingly energetic, requiring only two to five hours’ sleep at night, and to experience her thoughts as ``racing." She started to see symbolic meanings in things, especially sexual meanings, and began to suspect that innocent comments on television shows were referring to her. Over the next month, she became increasingly euphoric, irritable, and overtalkative. She started to believe that there was a hole in her head through which radar messages were being sent to her. These messages could control her thoughts or produce emotions of anger, sadness, or the like, that were beyond her control. She also believed that her thoughts could be read by people around her and that alien thoughts from other people were intruding themselves via the radar into her own head. She described hearing voices, which sometimes spoke about her in the third person and at other times ordered her to perform various acts, particularly sexual ones.

Her friends, concerned about Alice’s unusual behavior, took her to an emergency room, where she was evaluated and admitted to a psychiatric unit. After a day of observation, Alice was started on an antipsychotic, chlorpromazine, and lithium carbonate. Over the course of about three weeks, she experienced a fairly rapid reduction in all of the symptoms that had brought her to the hospital. The chlorpromazine was gradually reduced, and then discontinued. She was maintained thereafter on lithium carbonate alone. At the time of her discharge, after six weeks of hospitalization, she was exhibiting none of the symptoms reported on admission; but she was noted to be experiencing some mild hypersomnia, sleeping about ten hours a night, and loss of appetite and some feeling of being ``slowed down," which was worse in the mornings. She was discharged to live with some friends.

Approximately eight months after her discharge, Alice was taken off lithium carbonate by the psychiatrist in the college mental health clinic. She continued to do fairly well for the next few months, but then began to experience a gradual reappearance of symptoms similar to those that had necessitated her hospitalization. The symptoms worsened, and after two weeks she was readmitted to the hospital with almost the identical symptoms that she had when first admitted.
Alice responded in days to chlorpromazine and lithium; and, once again, the chlorpromazine was gradually discontinued, leaving her on lithium alone. As with the first hospitalization, at the time of her discharge, a little more than a year ago, she again displayed some hypersomnia, loss of appetite, and the feeling of being "slowed down." For the past year, while continuing to take lithium, she has been symptom free and functioning fairly well, getting a job in publishing and recently moving to New York to advance her career.

Alice’s father, when in his 40s, had had a severe episode of depression, characterized by hypersomnia, anorexia, profound psychomotor retardation, and suicidal ideation. Her paternal grandmother had committed suicide during what also appeared to be a depressive episode.
SCID Coding for “Radar Messages”

Module A:

Page A.1:  
A1=1
A2=1

Page A.12:  
A52=3 (3 years ago, began to feel depressed)
A53=1

Page A.13:  
A54=3 (loss of appetite; 10 lb. weight loss)
A55 is checked
A57=3 (trouble falling asleep; waking up too early)
A58 is checked
A60=1
A63=3 (severe fatigue)

Page A.14:  
A64=3 (feelings of worthlessness)
A65 is checked
A67=3 (difficulty concentrating)
A68 is checked
A70=1

Page A.15:  
A75=3
A76=3 (clinically significant)

Page A.16:  
A77=3 (not due to substance or GMC)

Page A.17:  
A78=3 (not due to simple bereavement)
A79=3 (past Major Depressive Episode)
A80=21 (age at onset)
A81=01 (number of episodes)

Page A.18:  
A83=1 (no current euphoric or irritable mood)

Page A.28:  
A126=3 (3 years ago, became increasingly euphoric and irritable)
A127 and A128 checked
A129=3 (hospitalized)

Page A.29:  
A130=1
A131=3 (required only 3-5 hours of sleep a night)
A132=3 (overtalkative)
A133=3 (began to experience her thoughts as “racing”)
A134=1
A135=1

Page A.30:  
A138=1
A139=3 (3 symptoms coded 3)
A140=3 (hospitalized)

Page A.31:  
A141=3 (not due to a substance or GMC)

Page A.32:  
A142=3 (past Manic Episode)
A143=21 (age of onset)
A144=02 (number of episodes)
Module B:

Page B.1: B1=3 (innocent comments on television shows were referring to her)
B2=1 (no clear malevolent intent of radar messages)
B3=1

Page B.2: B4=3 (“hole in her head”)
B5=1

Page B.3: B11=3 (radar messages.....could control her thoughts)
B14=3 (believed her thoughts could be read by other people around her)
B15=3 (all of the above)

Page B.4: B16=3 (voices)
B17=1 (sometimes talked about her in the third person but not a running commentary)
B18=1
B19-B21=1

Pages B.5 to B.7: all items=1

Module C:

Page C.1: C1 not checked, C2=1 (psychotic symptoms only during manic episodes)

Module D:

Page D.1: D1 not checked
D2=3 (Manic Episodes)
D3=3 (not due to GMC/Substance)
D4=3 (not superimposed on another psychotic disorder; not Schizoaffective)
D5=1 (most recent episode manic)

Page D.3: D11=1 (not rapid cycling)
D11a=Check marked for fewer than two Major Depressive episodes

Page D.10: D34=1
D35=012 (number of months since last in mood episode)
D36=7 (in full remission)
D37=21 (age of onset)

SCID DX: BIPOLAR DISORDER, IN FULL REMISSION
GAF: (Current) 75 (no more than slight impairment in functioning)
17. Appendix C: Evaluation Form for SCID Interview

Supervised interviews should be a part of training for all interviewers. Supervisors and trainers may find the set of scales on the next two pages helpful for evaluating and teaching interviewers.
### I. Interviewing Style

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<tr>
<td>1. Established rapport with subject</td>
<td>5</td>
<td>4</td>
<td>3</td>
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<td>n/a</td>
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<td>2. Explained purpose of interview</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
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<td>3. Handled subject’s questions adequately</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
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<td>n/a</td>
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<td>4. Recognized and dealt with subject’s emotional responses during the interview (e.g., anger, tearfulness, etc.)</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>n/a</td>
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### II. Obtaining Diagnostic Information

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<td>1. Elicited enough information in the Overview to understand the context and development of the problem</td>
<td>5</td>
<td>4</td>
<td>3</td>
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<td>2. Elicited adequate treatment history in Overview</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
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<td>3. Followed structure of the SCID whenever possible</td>
<td>5</td>
<td>4</td>
<td>3</td>
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<td>n/a</td>
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<td>4. Elicited a description of each symptom in subject’s own words</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>n/a</td>
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<td>5. Obtained enough information to make judgments on each item</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>n/a</td>
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<td>6. Modified questions when necessary to use language that was clear to subject</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>n/a</td>
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<tr>
<td>7. Modified questions when necessary to take into account information already obtained</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>n/a</td>
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<td>8. Resolved contradictions in subject’s story</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>n/a</td>
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<tr>
<td>9. Followed skip instructions correctly</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>n/a</td>
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<td>10. Appropriately skipped to sections to consider general medical or substance etiologies</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>n/a</td>
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<tr>
<td>11. Focused interview on time period under consideration (e.g., worst time during episode)</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>n/a</td>
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<td>12. Clearly differentiated symptoms that are easily confused (e.g., social phobia and fear of having a panic attack in a crowd; inability to concentrate and loss of interest)</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>n/a</td>
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<tr>
<td>13. Helped rambling subject to focus on the issue under consideration</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>n/a</td>
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<tr>
<td>14. Completed interview in a reasonable period of time (may vary from 45 minutes to 90 minutes, depending on complexity of history)</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>n/a</td>
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