USER'S GUIDE FOR THE

SCID-5-RV

STRUCTURED CLINICAL INTERVIEW FOR DSM-5® DISORDERS

RESEARCH VERSION

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Contents

1. INTRODUCTION

The Structured Clinical Interview for DSM-5 (SCID-5) is a semistructured interview guide for making the major DSM-5 diagnoses (formerly diagnosed on Axis I). It is administered by a clinician or trained mental health professional who is familiar with the DSM-5 classification and diagnostic criteria (American Psychiatric Association 2013). The interview 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-5 most appropriate for use with adults (age 18 and over); but with slight modification to the wording of the questions, it may be used with adolescents. The average person should be able to understand the language of the SCID-5. Some individuals with severe cognitive impairment, agitation, or severe psychotic symptoms cannot be interviewed using the SCID-5. This should be evident in the first 10 minutes of the Overview, and in such a case the SCID-5 may be used instead as a diagnostic checklist and decision tree, with diagnostic information obtained from other sources.

The SCID-5 can be used in a variety of ways:

- **To ensure that all of the major DSM-5 diagnoses are systematically evaluated.** For example, the SCID is often used as part of intake procedures in clinical settings and to help insure a comprehensive forensic diagnostic evaluation.

- **To select a study population.** For example, in a study of the effectiveness of a treatment for depression, the SCID-5 can be used to insure that all of the study subjects have symptoms that meet the DSM-5 criteria for Major Depressive Disorder and that all of the subjects with a history of any Substance Use Disorder in the past 12 months are excluded.

- **To characterize a study population in terms of current and past psychiatric diagnoses.** For example, diagnostic data that are obtained using the SCID-5 interview can be used by researchers, practitioners, policy makers, and the general public who are interested in prevalence and incidence estimates of psychiatric disorders among certain populations (e.g., adults in the United States).

- **To improve interviewing skills of students in the mental health professions,** including psychiatry, psychology, psychiatric social work, and psychiatric nursing. For example, the SCID-5 can provide trainees 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-5, students become familiar with the DSM-5 criteria and at the same time incorporate useful questions into their interviewing repertoire.

For the latest information about the SCID-5, including available translations, computer-assisted versions, training materials including videos and SCID knowledge examinations, and error corrections/revisions, please visit the SCID Web site: www.scid5.org.

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 (American Psychiatric Association 1980). Before 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 (Endicott and Spitzer 1978; Helzer et al. 1981). In 1983, work started on the SCID as an instrument for making DSM-III diagnoses in response to the widespread adoption of the DSM-III criteria as the standard language for describing research subjects. 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 recognized the need for a clinical diagnostic assessment procedure for making DSM-III diagnoses and issued a Request for 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 at New York State Psychiatric Institute received a 2-year grant to field-test the SCID and to determine its reliability in several different clinical and nonclinical subject groups (Spitzer et al. 1992; Williams et al. 1992). The SCID for DSM-III-R was published by American Psychiatric Press in May 1990 (Spitzer et al. 1990a, 1990b).

Work on the DSM-IV (American Psychiatric Association 1994) 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 followed, the most extensive of which were made in February 2001 when the SCID was updated for the DSM-IV text revision (DSM-IV-TR; American Psychiatric Association 2000).

Work on revising the SCID for DSM-5 (SCID-5) began in 2012. The multitude of changes in the DSM-5 criteria sets (American Psychiatric Association 2013) required the development of many new SCID questions, as well as adjustments to the SCID algorithm. (See Appendix A, "Overview of Changes in the SCID-5," for a summary of the major changes.) The opportunity was also taken to revisit all of the questions and make modifications in the wording even for criterion items that had not changed in DSM-5. The SCID-5 modular structure has been reorganized to correspond to the DSM-5 metastructure. Finally, the number of disorders assessed by the SCID-5 was expanded, with new sections added for Cyclothymic Disorder, Premenstrual Dysphoric Disorder, Separation Anxiety Disorder, Hoarding Disorder, Trichotillomania (Hair-Pulling Disorder), Excoriation (Skin-Picking) Disorder, Avoidant/ Restrictive Food Intake Disorder, Insomnia Disorder, Hypersomnolence Disorder, adult Attention-Deficit/Hyperactivity Disorder, Intermittent Explosive Disorder, and Gambling Disorder. Draft revisions were reviewed by DSM-5 Work Group members and experienced SCID users during the first half of 2013, and field-testing of the SCID-5 began in late 2013. The final version of the SCID-5 was submitted to American Psychiatric Publishing for publication in November 2014. As was the case with the DSM-IV SCID, errors will be corrected and revisions made on an ongoing basis as the need arises. Please refer to the SCID-5 web site for the most up-to-date information regarding ongoing revisions.

3. VERSIONS OF THE SCID

The SCID was originally designed to be a single document that could be used by both researchers and clinicians. This involved making the SCID detailed enough to meet the needs of the research community, but still user-friendly enough for use by clinicians to enhance the reliability and validity of their diagnostic assessments. This duality of purpose ultimately created problems for researchers because a lot of potentially useful diagnostic information was left out of the DSM-III-R version of the SCID in order to keep it from becoming too cumbersome (e.g., most of the subtypes). However, many clinicians felt that the amount of detail that was included in the SCID still rendered it too long and complex. Moreover, it also became clear that for clinical trials in which the SCID was used to determine whether potential subjects' conditions meet the diagnostic inclusion and exclusion criteria for particular protocols, the standard research version included a lot of extraneous information that was not needed for clinical trials. Thus, the need also arose for a version of the SCID that could be tailored specifically to the inclusion/exclusion criteria for clinical trials.

To meet these divergent needs, the SCID-5 has been split into three separate versions: the **Research Version** (SCID-5-RV), which includes a number of features intended to facilitate its use in research studies; the **Clinician Version** (SCID-5-CV), which has been streamlined for use in clinical settings; and the **Clinical Trials Version** (SCID-5-CT), which is available for customization to conform to the inclusion/exclusion criteria for a specific clinical trial. Details about the three versions are provided below.

3.1 Research Version of the SCID (SCID-5-RV)

This User's Guide pertains specifically to the SCID-5-RV. As the most comprehensive version of the SCID-5, the SCID-5-RV contains more disorders than the SCID-5-CV and includes all of the subtypes and severity and course specifiers. An important feature of the SCID-5-RV is its customizability, allowing the instrument to be tailored to meet the requirements of a particular study. As described in Section 5, "Steps for Customizing the SCID-5-RV for Your Study," the SCID-5-RV is distributed in the form of 19 individual document files (the User's Guide and 18 diagnostic module files) that the researcher must assemble in order to produce a customized version of the SCID.

The SCID-5-RV comes in a standard, "core" configuration that includes those disorders most researchers are likely to want to assess for routinely in most studies (see Table 1), as well as an "enhanced" configuration that also includes the assessment of a number of optional disorders (see Table 2). (Tables 1 and 2 are located in Section 4, "Diagnostic Coverage of Core and Enhanced Versions of the SCID-5-RV.") Moreover, several of the SCID-5-RV modules are available in two different versions (see Table 3 in Section 5, "Steps of Customizing the SCID-5-RV for Your Study"), of which one is selected depending on the needs of the study. For example, there are two versions of the Overview: one for use in studies in which the subjects are self-identified as psychiatric patients and the other for use in studies in which the subjects are not necessarily psychiatric patients (e.g., for studies in general medical or community settings). Thus, there is truly no "off-the-shelf version" of the SCID-5-RV. The researcher must always at least minimally customize the SCID-5-RV by choosing which module version to include when there are alternative module forms to select. Furthermore, the researcher may decide to customize individual modules specifically for a particular study; for example, by leaving out particular disorders or specifiers that are not of interest to the study.

To facilitate customization, the SCID-5-RV is not published as a bound volume but instead the diagnostic modules can be downloaded from the American Psychiatric Publishing Web site (www.appi.org) as either 18 PDF files (which can be printed out by the researcher and "bound" together for ease of use) or as 18 Microsoft (MS) Word documents that can be modified by the researcher in order to remove unneeded elements (e.g., certain specifiers), alter the flow through the interview, or add additional scales (e.g., severity rating scales) of the researcher's choosing. (See Section 5, "Steps for Customizing the SCID-5-RV for Your Study," and Appendix B, "Guidelines for Customizing the SCID-5-RV for Particular Studies," in this User's Guide.)

3.2 Clinician Version of the SCID (SCID-5-CV)

The SCID-5-CV is published as a bound booklet by American Psychiatric Publishing and is an abridged and reformatted version of the SCID-5-RV that covers those diagnoses most commonly seen in clinical settings. Despite the "clinician" designation, the SCID-5-CV can be used in research settings as long as the disorders of particular interest to the researcher are among those included in the SCID-5-CV.

The SCID-5-CV differs from the SCID-5-RV in several ways. First, the specifiers included in the SCID-5-CV are limited to those that have an impact on the diagnostic coding. Thus, only the severity, psychosis, and remission specifiers for Bipolar Disorder and Major Depressive Disorder are included in the SCID-5-CV because these affect the choice of diagnostic code. Similarly, the Attention-Deficit/Hyperactivity Disorder (ADHD) presentation types (i.e., predominantly inattentive, predominantly hyperactive/impulsive, and combined) are included because they are also required to determine the diagnostic code. Second, the full criteria sets for a number of disorders (e.g., Anorexia Nervosa, Hoarding Disorder) included in the SCID-5-RV do not appear in the SCID-5-CV and instead are replaced with screening questions for those disorders. If the patient answers one of these questions in the affirmative, the clinician needs to follow up with an unstructured clinical assessment of the diagnostic requirements for that disorder. (To facilitate this process, the SCID-5-CV includes the DSM-5 page numbers for the corresponding criteria sets.) Finally, although most of the disorders in the SCID-5-RV are assessed for both current and lifetime time frames, the SCID-5-CV focuses largely on whether criteria are currently met, because the current clinical status of a disorder is most relevant for treatment decisions. The only disorders in the SCID-5-CV that also include a lifetime assessment are Major Depressive Disorder, Bipolar I and II Disorders, Schizophrenia and the Other Psychotic Disorders, Panic Disorder, and Posttraumatic Stress Disorder (PTSD).

3.3 Clinical Trials Version of the SCID (SCID-5-CT)

Originally developed in partnership with i3 Research, the SCID-5-CT is a modified version of the SCID-5-RV that has been reformatted, streamlined, and optimized for use in clinical trials that incorporate typical inclusion and exclusion criteria. SCID-CT templates have been developed for clinical trials for treatments of Major Depressive Disorder, Bipolar Disorder, Schizophrenia, Generalized Anxiety Disorder, PTSD, and ADHD. An additional "exclusionary" SCID-5-CT has also been developed for situations in which the SCID is used primarily to exclude individuals with disorders listed in the exclusion criteria for the study (e.g., for drug indications not included in the SCID, like Major Neurocognitive Disorder). In order to produce a protocol-specific SCID-CT, the appropriate template must be customized to conform to the particular inclusion and exclusion criteria for the protocol. Visit www.scid5.org for more information on obtaining a commercial license and to arrange for protocol-specific customization of the SCID-CT.

4. DIAGNOSTIC COVERAGE OF CORE AND ENHANCED VERSIONS OF THE SCID-5-RV

During the development of the SCID-5, initial plans included greatly expanding the number of disorders included. However, in response to concerns raised by a number of reviewers about the increasing complexity and time demands of the SCID-5-RV, these additional disorders are instead available on an optional basis. The decision as to which disorders are optional or included in the core configuration was based on the results of a survey of users of the DSM-IV SCID-RV.

Two versions of the SCID-5-RV are available:

- A standard **core configuration** (see Table 1) comprises the Overview and the basic SCID-5 disorders.
- An **enhanced configuration** (see Table 2) comprises the Overview and both the standard core disorders and the following 13 optional disorders: Separation Anxiety Disorder, Hoarding Disorder, Body Dysmorphic Disorder, Trichotillomania (Hair-Pulling Disorder), Excoriation Disorder (Skin-Picking Disorder), Insomnia Disorder, Hypersomnolence Disorder, Substance/Medication-Induced Sleep Disorder, Avoidant/Restrictive Food Intake Disorder, Somatic Symptom Disorder, Illness Anxiety Disorder, Intermittent Explosive Disorder, and Gambling Disorder.

Table 1: Diagnostic Coverage of the Core SCID-5-RV

Module A **Mood Episodes, Cyclothymic Disorder, Persistent Depressive Disorder, and Premenstrual Dysphoric Disorder**	Major Depressive Episode Manic Episode Hypomanic Episode Cyclothymic Disorder Persistent Depressive Disorder (Dysthymia) Premenstrual Dysphoric Disorder Bipolar Disorder Due to Another Medical Condition (AMC) Substance/Medication-Induced Bipolar Disorder Depressive Disorder Due to AMC Substance/Medication-Induced Depressive Disorder
Module B **Psychotic and Associated Symptoms**	Delusions Hallucinations Disorganized Speech and Behavior Catatonic Behavior Negative Symptoms
Module C **Differential Diagnosis of Psychotic Disorders**	Schizophrenia Schizophreniform Disorder Schizoaffective Disorder Delusional Disorder Brief Psychotic Disorder Psychotic Disorder Due to AMC Substance/Medication-Induced Psychotic Disorder Other Specified Psychotic Disorder

Table 1: Diagnostic Coverage of the Core SCID-5-RV *(continued)*

Module D **Differential Diagnosis of Mood Disorders**	Bipolar I Disorder Bipolar II Disorder Other Specified Bipolar Disorder Major Depressive Disorder Other Specified Depressive Disorder
Module E **Substance Use Disorders**	Alcohol Use Disorder Sedative, Hypnotic, or Anxiolytic Use Disorder Cannabis Use Disorder Stimulant Use Disorder Opioid Use Disorder Inhalant Use Disorder Phencyclidine Use Disorder Other Hallucinogen Use Disorder Other or Unknown Substance Use Disorder
Module F **Anxiety Disorders**	Panic Disorder Agoraphobia Social Anxiety Disorder Specific Phobia Generalized Anxiety Disorder Anxiety Disorder Due to AMC Substance/Medication-Induced Anxiety Disorder Other Specified Anxiety Disorder
Module G **Obsessive-Compulsive and Related Disorders**	Obsessive-Compulsive Disorder Other Specified Obsessive-Compulsive and Related Disorder Obsessive-Compulsive and Related Disorder Due to AMC Substance/Medication-Induced Obsessive-Compulsive and Related Disorder
Module I **Feeding and Eating Disorders**	Anorexia Nervosa Bulimia Nervosa Binge-Eating Disorder Other Specified Eating Disorder
Module K **Externalizing Disorders**	Adult Attention-Deficit/Hyperactivity Disorder
Module L **Trauma- and Stressor-Related Disorders**	Acute Stress Disorder Posttraumatic Stress Disorder Adjustment Disorder Other Specified Trauma- and Stressor-Related Disorder

Table 2: Diagnostic Coverage of the Enhanced SCID-5-RV (with ***Optional Disorders*** indicated in ***bold italics***)

Module A **Mood Episodes, Cyclothymic Disorder, Persistent Depressive Disorder, and Premenstrual Dysphoric Disorder**	Major Depressive Episode Manic Episode Hypomanic Episode Cyclothymic Disorder Persistent Depressive Disorder (Dysthymia) Premenstrual Dysphoric Disorder Bipolar Disorder Due to Another Medical Condition (AMC) Substance/Medication-Induced Bipolar Disorder Depressive Disorder Due to AMC Substance/Medication-Induced Depressive Disorder
Module B **Psychotic and Associated Symptoms**	Delusions Hallucinations Disorganized Speech and Behavior Catatonic Behavior Negative Symptoms
Module C **Differential Diagnosis of Psychotic Disorders**	Schizophrenia Schizophreniform Disorder Schizoaffective Disorder Delusional Disorder Brief Psychotic Disorder Psychotic Disorder Due to AMC Substance/Medication-Induced Psychotic Disorder Other Specified Psychotic Disorder
Module D **Differential Diagnosis of Mood Disorders**	Bipolar I Disorder Bipolar II Disorder Other Specified Bipolar Disorder Major Depressive Disorder Other Specified Depressive Disorder
Module E **Substance Use Disorders**	Alcohol Use Disorder Sedative, Hypnotic, or Anxiolytic Use Disorder Cannabis Use Disorder Stimulant Use Disorder Opioid Use Disorder Inhalant Use Disorder Phencyclidine Use Disorder Other Hallucinogen Use Disorder Other or Unknown Substance Use Disorder
Module F **Anxiety Disorders**	Panic Disorder Agoraphobia Social Anxiety Disorder Specific Phobia Generalized Anxiety Disorder ***Separation Anxiety Disorder*** **(optional)** Anxiety Disorder Due to AMC Substance/Medication-Induced Anxiety Disorder Other Specified Anxiety Disorder

Table 2: Diagnostic Coverage of the Enhanced SCID-5-RV (with ***Optional Disorders*** indicated in ***bold italics***) *(continued)*

Module G **Obsessive-Compulsive and Related Disorders**	Obsessive-Compulsive Disorder ***Hoarding Disorder* (optional)** ***Body Dysmorphic Disorder* (optional)** ***Trichotillomania* (optional)** ***Excoriation Disorder* (optional)** Other Specified Obsessive-Compulsive and Related Disorder Obsessive-Compulsive and Related Disorder Due to AMC Substance/Medication-Induced Obsessive-Compulsive and Related Disorder
Module H ***Sleep-Wake Disorders (optional)***	***Insomnia Disorder* (optional)** ***Hypersomnolence Disorder* (optional)** ***Substance/Medication-induced Sleep Disorder* (optional)**
Module I **Feeding and Eating Disorders**	Anorexia Nervosa Bulimia Nervosa Binge-Eating Disorder ***Avoidant/Restrictive Food Intake Disorder* (optional)** Other Specified Feeding or Eating Disorder
Module J ***Somatic Symptom and Related Disorders (optional)***	***Somatic Symptom Disorder* (optional)** ***Illness Anxiety Disorder* (optional)**
Module K **Externalizing Disorders**	Adult Attention-Deficit/Hyperactivity Disorder ***Intermittent Explosive Disorder* (optional)** ***Gambling Disorder* (optional)**
Module L **Trauma- and Stressor-Related Disorders**	Acute Stress Disorder Posttraumatic Stress Disorder Adjustment Disorder Other Specified Trauma- and Stressor-Related Disorder

5. STEPS FOR CUSTOMIZING THE SCID-5-RV FOR YOUR STUDY

Before you can start using the SCID-5-RV for your study, you need to first "build" your version of the SCID-RV from its component documents. (There is no single document containing the entire SCID-RV; only the SCID-CV [clinician version] comes configured as a single document that can be used "as is.") The SCID-5-RV is distributed in the form of 19 document files (the User's Guide and 18 diagnostic module files) available as either PDF files or modifiable MS Word files; the format is selected at the time of purchase. (The 18 diagnostic module files are listed in the center column of Table 3.) From these 18 diagnostic module files, a customized version of the SCID-5-RV is constructed to meet the needs of your study.

STEP 1: DETERMINING WHAT YOU WANT TO INCLUDE IN YOUR CUSTOMIZED SCID-5-RV

The first step in creating your customized SCID-5-RV is to determine what options are most compatible with your study's needs. To guide you in this process, answer the questions in the series below:

1. Do you want to assess just the "core" disorders, or do you want a more comprehensive assessment that includes some (or all) of the "optional" disorders? Your first decision is whether you want to administer the standard core SCID or the enhanced SCID, which includes the optional disorders.

The core SCID includes:

- Summary Score Sheet (Document 1)
- Overview (Patient or Nonpatient Version; Documents 2a or 2b)
- Standard Screening Module (with 15 screening questions; Document 3a)
- Modules A, B, C, D, E, F, G, I, K, and L (without having inserted any of the optional disorders contained in Document 13, as well as excluding optional Module H [Sleep-Wake Disorders] and optional Module J [Somatic Symptom and Related Disorders]).

The enhanced SCID includes:

- Summary Score Sheet (Document 1)
- Overview (Patient or Nonpatient Version; Documents 2a or 2b)
- Enhanced Screening Module (with 30 screening questions; Document 3b)
- Modules A, B, C, D, E, F, G, H, I, J, K, and L (with Modules F, G, I, and K modified to include optional disorders that are contained in Document 13).

To make the flow through the SCID-5-RV work for both the standard core version and the enhanced version (i.e., with optional modules), certain skip instructions in the SCID contain the word "*OR*" to indicate that during the SCID interview, the interviewer must choose between the two SCID locations to skip to, depending on whether or not the optional disorder (always listed as the second one in the pair) is being assessed. For example, most of the skip instructions in the Obsessive-Compulsive Disorder (OCD) criteria set in Module G read "GO TO ***OTHER SPECIFIED OC AND RELATED DISORDER,*** G.8 *OR* GO TO ***HOARDING DISORDER (OPTIONAL),*** Opt-G.1." When using the core SCID (or a version of the enhanced SCID that has been configured to exclude the assessment of Hoarding Disorder), the first choice, "GO TO ***OTHER SPECIFIED OC AND RELATED DISORDER***" should be picked, which takes the interviewer to the assessment of Other Specified Obsessive Compulsive and Related Disorder on page G.8, the typical end of Module G. If the enhanced SCID has been configured to include the assessment of

Hoarding Disorder, the second choice, "GO TO ***HOARDING DISORDER (OPTIONAL),*** Opt-G.1" should be picked, and the interviewer continues with the assessment for Hoarding Disorder. When the Hoarding Disorder assessment is completed, the interviewer moves on to the assessment of Body Dysmorphic Disorder (also optional), then to Trichotillomania, and then to Excoriation Disorder. The skip instructions at the end of Excoriation Disorder direct the interviewer to "GO TO ***OTHER SPECIFIED OC AND RELATED DISORDER*,** G.8," bringing the interviewer back again into the flow of the core SCID.

> Note: Those who have purchased the MS Word version of the SCID-5-RV documents may want to customize all of these double "GO TO" boxes based on their chosen SCID configuration in order to eliminate the one that the raters should not follow. For example, users of the core SCID would replace "GO TO ***OTHER SPECIFIED OC AND RELATED DISORDER,*** G.8 *OR* ***HOARDING DISORDER (OPTIONAL),*** Opt-G.1" with" GO TO ***OTHER SPECIFIED OC AND RELATED DISORDER,*** G.8," whereas users of the enhanced SCID that includes an assessment of Hoarding Disorder would replace "GO TO ***OTHER SPECIFIED OC AND RELATED DISORDER,*** G.8 *OR* ***HOARDING DISORDER (OPTIONAL),*** Opt-G.1" with "GO TO ***HOARDING DISORDER (OPTIONAL),*** Opt-G.1." Please refer to Appendix B for instructions on how to modify the SCID "GO TO" instructions in the MS Word version of the SCID.

Although it is not necessary to include ALL of the optional disorders in a module in your customized enhanced SCID, the combination of the way the skip instructions have been set up (discussed above) and the modular nature of the SCID make it most convenient to either assess all of the optional disorders within a SCID module or none of them. For those modules that include only one optional disorder (i.e., Anxiety Disorders and Feeding and Eating Disorders), it is straightforward to either include the optional disorder (i.e., Separation Anxiety Disorder in the Anxiety Disorders Module or Avoidant/Restrictive Food Intake Disorder for the Feeding and Eating Disorder Module) or to exclude it, given that skip instructions in the respective modules are already set up for either contingency (e.g., the skip instructions in Past Generalized Anxiety Disorder instruct the interviewer to either "GO TO ***OTHER SPECIFIED ANXIETY DISORDER*** F.31 *OR* ***SEPARATION ANXIETY DISORDER*** Opt-F.1"). For those modules that include more than one optional disorder such as the OC and Related Disorders module, which includes optional assessments of Hoarding Disorder, Body Dysmorphic Disorder, Trichotillomania, and Excoriation Disorder, it is most straightforward to either skip the assessment of all of the optional Module G disorders or to assess all of them in sequence. For example, if the assessment of the optional OC and related disorders is left out of the customized SCID configuration, the interviewer would pick the "GO TO ***OTHER SPECIFIED OC AND RELATED DISORDER*,** G.8" choice within the skip instruction. If the assessment of all of the OC and Related Disorders is part of the SCID configuration, then the interviewer would pick the "GO TO ***HOARDING DISORDER (OPTIONAL),*** Opt-G.1" choice and continue with the assessment of Hoarding Disorder, Body Dysmorphic Disorder, Trichotillomania, and Excoriation Disorder before returning to the assessment of Other OC and Related Disorder. Similarly, all of the optional Sleep-Wake Disorders and Somatic Symptom and Related Disorders can be either assessed or skipped by either including or not including Optional Modules H and J in the customized SCID configuration.

If, however, you want to assess only one of the optional disorders within a module but skip the others, you will have to insert only the pages for the disorder you want to assess and then adjust the relevant skip instructions in the MS Word version of the SCID documents, so that only that disorder is included in the SCID diagnostic flow. For example, consider the situation in which the investigator is interested in assessing only Body Dysmorphic Disorder—and not Hoarding Disorder, Trichotillomania, and Excoriation Disorder. When configuring the SCID, the investigator would first insert into Module G (between pages G.7 and G.8) pages Opt-G.6 through Opt-G.9 (the pages for the assessment of Body Dysmorphic Disorder), leaving out the pages for the other optional disorders (i.e., Pages Opt-G.1 through Opt-G.5,

and pages Opt-G.10 through Opt-G.15). The next step would be to modify the skip instructions, both within the items for OCD in Module G (pages G1-G7) as well as within the items in Body Dysmorphic Disorder (pages Opt-G6-Opt-G.9) to make sure that the skip instructions in OCD go to Body Dysmorphic Disorder and that those in Body Dysmorphic Disorder go to Other Specified OC and Related Disorder instead of to Trichotillomania as they now do. For example, for the item in which the criteria for OCD are summarized on page G.5 ("OBSESSIVE COMPULSIVE DISORDER CRITERIA A, B, C, D, AND E ARE CODED '3.'"), the instruction under the rating of "1" on page G.5 now directs the interviewer to "GO TO ***OTHER SPECIFIED OC AND RELATED DISORDER*** G.8, *OR* GO TO ***HOARDING DISORDER (OPTIONAL),*** Opt-G.1." This instruction (as well as others like it) would need to be changed to "GO TO ***BODY DYSMORPHIC DISORDER,*** Opt-G.5." Similarly, every instructions within the assessment of Body Dysmorphic Disorder directing the interviewer to skip to Trichotillomania ("GO TO ***TRICHOTILLOMANIA,*** Opt-G.10") would need to be changed to "GO TO ***OTHER SPECIFIED OC AND RELATED DISORDER,*** G.8" in order to bring the interviewer back to Module G.

Document 3a contains the Screening Module (15 questions) used for the core SCID, whereas *Document 3b* contains the Screening Module (30 questions) used for the enhanced SCID. Note that the enhanced screening module (Document 3b) includes screening questions for all of the optional disorders (except Substance/Medication-Induced Sleep Disorder, which is only diagnosed during the course of the evaluation of Insomnia Disorder and Hypersomnolence Disorder). If you are using only a subset of the optional disorders in your customized SCID-5-RV, you might want to skip those screening questions corresponding to optional disorders that are not being included.

2. Do you want to use the Patient or Nonpatient Version of the Overview? The selection of which version of the Overview you want depends on the type of subjects being assessed. *Document 2a* contains the Patient Version, which is geared for the assessment of individuals who are self-identified as psychiatric patients. The questions are designed with the assumption that the person is currently in treatment or has sought treatment in the past. It therefore includes a detailed section for describing the presenting problem and its course. *Document 2b* contains the Nonpatient Version, which makes no assumptions regarding whether or not the interview subject has been a psychiatric patient currently or in the past. Thus, it includes several questions designed to identify possible periods of undiagnosed psychopathology (e.g., "Thinking back over your whole life, when were you the most upset?").

3. Do you want to include the diagnostic specifiers in Module A (Mood Episodes and Selected Disorders)? The selection of which version of Module A to use depends on whether or not you are interested in assessing the following specifiers that apply to current Major Depressive Episode (MDE), current Manic Episode, current Hypomanic Episode, current Cyclothymic Disorder, and current Persistent Depressive Disorder: With Anxious Distress, With Mixed Features, With Peripartum Onset, With Catatonia, With Melancholic Features, and With Atypical Features. *Document 4a* contains the version of Module A that includes all of these specifiers, whereas *Document 4b* contains the version without these specifiers.

4. Do you want to screen for psychotic symptoms or conduct a full assessment of the Psychotic Disorders? The selection of which version of Modules B and C to use depends on whether or not you are interested in assessing the full complement of positive and negative psychotic symptoms, as well as determining the differential diagnosis of these symptoms. *Document 5a* contains the version with both Module B (assessing the full complement of psychotic symptoms) and Module C (determining the differential diagnosis of the symptoms). *Document 5b* contains a combined Psychotic Screening Module B/C, which assesses only the lifetime presence of delusions and hallucinations, and is generally used for the purpose of screening out from a study cases with a lifetime history of psychotic symptoms.

5. Do you want a general or a detailed trauma screening? The selection of which version of Module L to use depends on whether you want to use the standard trauma history or the more extensive alternative trauma history as a prelude to the diagnoses of Acute Stress Disorder and PTSD. *Document 12a* contains the standard trauma screener that includes 6 general questions covering the various categories of trauma (e.g., "Have you ever seen another person killed or dead, or badly hurt?"). *Document 12b* includes the alternative trauma history of 28 questions covering various specific types of trauma (e.g., "Ever witness a life-threatening medical event happen to someone close to you, like needing to be resuscitated?").

STEP 2: CONSTRUCTING YOUR CUSTOMIZED SCID-5-RV

Once you have determined what options fit best with your study, you're ready to construct your customized SCID-5-RV. Below are the instructions for constructing the core SCID-5-RV and the enhanced SCID-5-RV. Please refer to Table 3 for a summary of the names of the document files, their contents, and how they correspond to the SCID modules.

Instructions for Constructing the Core SCID

1) Start with the Summary Score Sheet (Document 1).

2) Select either the Overview—Patient Version (Document 2a) or the Overview—Nonpatient Version (Document 2b).

3) Select the Core Screening Module (with 15 questions; Document 3a).

4) Add the Diagnostic Modules:

   - Module A—select either Module A With Specifiers (Document 4a) or Module A Without Specifiers (Document 4b)
   - Modules B and C—select either Modules B and C to assess Psychotic Disorders (Document 5a) or Module B/C to screen for psychotic symptoms (Document 5b)
   - Module D (Document 6)
   - Module E (Document 7)
   - Module F (Document 8)
   - Module G (Document 9)
   - Module I (Document 10)
   - Module K (Document 11)
   - Module L—select Module L for the standard trauma screening (Document 12a) or Module Alt-L for a detailed trauma screening (Document 12b)

Instructions for Constructing the Enhanced SCID

1) Start with the Summary Score Sheet (Document 1).

2) Select either the Overview—Patient Version (Document 2a) or the Overview—Nonpatient Version (Document 2b).

3) Select the Optional Screening Module (with 30 questions; Document 3b).

4) Add the Diagnostic Modules:

   - Module A—select either Module A With Specifiers (Document 4a) or Module A Without Specifiers (Document 4b)
   - Modules B and C—select either Modules B and C to assess Psychotic Disorders (Document 5a) or Module B/C to screen for psychotic symptoms (Document 5b)
   - Module D (Document 6)
   - Module E (Document 7)
   - Module F (Document 8)
   - Module G (Document 9)
   - Module I (Document 10)
   - Module K (Document 11)
   - Module L—select Module L for the standard trauma screening (Document 12a) or Module Alt-L for a detailed trauma screening (Document 12b)

5) Insert the pages containing those Optional Disorders you are interested in assessing (taken from Document 13) into the respective modules as follows:

   - Pages Opt-F.1 through Opt-F.4 (Separation Anxiety Disorder) are inserted right after page F.30 and before F.31 (Other Specified Anxiety Disorder).
   - Pages Opt-G.1 through Opt-G.15 (Hoarding Disorder, Body Dysmorphic Disorder, Trichotillomania, Excoriation Disorder) are inserted right after page G.7 and before page G.8 (Other Specified Obsessive-Compulsive and Related Disorder).
   - Pages Opt-H.1 through Opt-H.11 (the optional Sleep-Wake Disorders module) are inserted right after Page G.16 (the last page in Module G) and before page I.1 (the first page in the Feeding and Eating Disorders module).
   - Pages Opt-I.1 through Opt-I.3 (Avoidant/Restrictive Food Intake Disorder) are inserted right after page I.9 and before page I.10 (the first page of Other Specified Feeding or Eating Disorder).
   - Pages Opt-J.1 through Opt-J.4 (Somatic Symptom and Related Disorders module) are inserted after page I.12 (the last page of the Feeding and Eating Disorders module) and before page K.1 (the first page of the Externalizing Disorders module).
   - Pages Opt-K.1 through Opt-K.7 are inserted at the end of the Module K (right after page K.6) and before L.1 (the first page of the Trauma- and Stressor-Related Disorders module).

As discussed above, if you want to include only one of the optional disorders contained within a module, you will need to insert only the relevant pages and modify the skip instructions accordingly.

Table 3: Guide to Customizing the SCID-5-RV From SCID-5 Document Files

SCID Modules	SCID-5 Document Files *(actual document file name in parentheses)*	Included Disorders (**boldface** disorders are new to the SCID-5)
Summary Score Sheet	**Document 1** *(1-SCID-5-RV_Scoresheet):* Summary Score Sheet without specifiers listed	—
Overview (select either 2a or 2b)	**Document 2a** *(2a-SCID-5-RV_Patient_Overview):* Patient Version (for subjects self-identified as psychiatric patients) **Document 2b** *(2b-SCID-5-RV_Non-patient Overview):* Nonpatient Version (for those not self-identified as psychiatric patients) Note: Select the version of the Overview depending on the types of subjects being assessed.	—
Screening Module (select either 3a or 3b)	**Document 3a** *(3a-SCID-5-RV_Core_Screening):* Standard "core" screening excluding optional disorders (15 questions) **Document 3b** *(3b-SCID-5-RV_Enhanced screening):* "Enhanced" screening including optional disorders (30 questions) Note: 3a to be used with core SCID and 3b to be used with enhanced SCID.	—
Module A Mood Episodes and Selected Mood Disorders (select either 4a or 4b)	**Document 4a** *(4a-SCID-5-RV_Module A_with_specifiers):* Version includes specifiers (e.g., With Anxious Distress) for current Major Depressive Episode (MDE), current Manic Episode, current Hypomanic Episode, current Cyclothymic Disorder, and current Persistent Depressive Disorder **Document 4b** *(4b-SCID-5-RV_Module A_without_specifiers):* Version without above noted specifiers Note: 4b, a greatly shortened version of Module A without most of the mood specifiers, is available for those studies for which the assessment of such specifiers is not important.	Current and Past MDE Current and Past Manic Episode Current and Past Hypomanic Episode **Current Cyclothymic Disorder** Current and **Past** Persistent Depressive Disorder **Premenstrual Dysphoric Disorder** Bipolar Disorder Due to Another Medical Condition (AMC) Substance/Medication-Induced Bipolar Disorder Depressive Disorder Due to AMC Substance/Medication-Induced Depressive Disorder

Table 3: Guide to Customizing the SCID-5-RV From SCID-5 Document Files *(continued)*

SCID Modules	SCID-5 Document Files *(actual document file name in parentheses)*	Included Disorders (**boldface** disorders are new to the SCID-5)
Modules B and C **Psychotic Symptoms and Psychotic Differential Diagnosis** (select either 5a or 5b)	**Document 5a** *(5a-SCID-5-RV_Modules B and C):* Includes both Module B (Psychotic and Associated Symptoms) and Module C (Differential Diagnosis of Psychotic Disorders) **Document 5b** *(5b-SCID-5-RV_Module BC Screen):* Includes a combined Module B/C (Psychotic Screening Module) Note: Module B/C (Psychotic Screening Module) is used instead of the full Module B and Module C in studies where it is not important to determine which Psychotic Disorder diagnosis accounts for the psychotic symptoms (i.e., where the interviewer is screening out patients with history of psychosis).	*For 5a only:* Schizophrenia Schizophreniform Disorder Schizoaffective Disorder Delusional Disorder Brief Psychotic Disorder Other Specified Psychotic Disorder Psychotic Disorder Due to AMC Substance/Medication-Induced Psychotic Disorder
Module D **Mood Differential Diagnosis**	**Document 6** *(6-SCID-5-RV_Module D):* Module D	Bipolar I Disorder Bipolar II Disorder Other Specified Bipolar Disorder Major Depressive Disorder Other Specified Depressive Disorder
Module E **Substance Use Disorders**	**Document 7** *(7-SCID-5-RV_Module E):* Module E	Alcohol Use Disorder Sedative, Hypnotic, or Anxiolytic Use Disorder Cannabis Use Disorder Stimulant Use Disorder Opioid Use Disorder Inhalant Use Disorder Phencyclidine Use Disorder Other Hallucinogen Use Disorder Other or Unknown Substance Use Disorder
Module F **Anxiety Disorders**	**Document 8** *(8-SCID-5-RV_Module F):* Module F Note: The pages containing the optional assessment of Separation Anxiety Disorder are physically located in Document 13, the Optional Disorders Repository document.	Panic Attack Panic Disorder Agoraphobia Social Anxiety Disorder Specific Phobia Current and **Past** Generalized Anxiety Disorder **Separation Anxiety Disorder** (optional) Other Specified Anxiety Disorder Anxiety Disorder Due to AMC Substance/Medication-Induced Anxiety Disorder

Table 3: Guide to Customizing the SCID-5-RV From SCID-5 Document Files *(continued)*

SCID Modules	SCID-5 Document Files *(actual document file name in parentheses)*	Included Disorders (**boldface** disorders are new to the SCID-5)
Module G **Obsessive-Compulsive and Related Disorders**	**Document 9** *(9-SCID-5-RV_Module G):* Module G Note: The pages containing the optional assessments of Hoarding Disorder, Body Dysmorphic Disorder, Trichotillomania, and Excoriation Disorder are physically located in Document 13, the Optional Disorders Repository document.	Obsessive-Compulsive Disorder **Hoarding Disorder** (optional) **Body Dysmorphic Disorder** (optional) **Trichotillomania** (optional) **Excoriation Disorder** (optional) **Other Specified Obsessive-Compulsive and Related Disorder** **Obsessive-Compulsive and Related Disorder Due to AMC** **Substance/Medication-Induced Obsessive-Compulsive and Related Disorder**
Module H **Sleep-Wake Disorders (optional)**	Note: All Sleep-Wake Disorders are physically located in Document 13, the Optional Disorders Repository document.	**Insomnia Disorder** (optional) **Hypersomnolence Disorder** (optional) **Substance/Medication-Induced Sleep Disorder** (optional)
Module I **Feeding and Eating Disorders**	**Document 10** *(10-SCID-5-RV_Module I):* Module I Note: The pages containing the optional assessment of Avoidant/Restrictive Food Intake Disorder (ARFID) are physically located in Document 13, the Optional Disorders Repository document.	Anorexia Nervosa Bulimia Nervosa Binge-Eating Disorder **ARFID** (optional) Other Specified Feeding or Eating Disorder
Module J **Somatic Symptom and Related Disorders (optional)**	Note: All Somatic Symptom and Related Disorders are physically located in Document 13, the Optional Disorders Repository document.	Somatic Symptom Disorder (optional) Illness Anxiety Disorder (optional)
Module K **Externalizing Disorders**	**Document 11** *(11-SCID-5-RV_Module K):* Module K Note: The pages containing the optional assessment of Intermittent Explosive Disorder and Gambling Disorder are physically located in Document 13, the Optional Disorders Repository document.	**Adult Attention-Deficit/Hyperactivity Disorder** **Intermittent Explosive Disorder** (optional) **Gambling Disorder** (optional)
Module L **Trauma- and Stressor-Related Disorders** (select either 12a or 12b)	**Document 12a** *(12a-SCID-5-RV_Module L_standard_trauma):* Module L (with standard trauma assessment) **Document 12b** *(12b-SCID-5-RV_Module L_detailed_trauma):* Module L (with alternative detailed trauma history assessment)	Acute Stress Disorder Posttraumatic Stress Disorder Adjustment Disorder **Other Specified Trauma- and Stressor-Related Disorder**

Table 3: Guide to Customizing the SCID-5-RV From SCID-5 Document Files *(continued)*

SCID Modules	SCID-5 Document Files *(actual document file name in parentheses)*	Included Disorders (**boldface** disorders are new to the SCID-5)
	Document 13 *(13-SCID-5-RV_Optional_Disorders):* Optional Disorders Repository; this is the physical location for all of the optional disorders.	**Separation Anxiety Disorder** (optional) **Hoarding Disorder** (optional) Body Dysmorphic Disorder (optional) **Trichotillomania** (optional) **Excoriation Disorder** (optional) **Insomnia Disorder** (optional) **Hypersomnolence Disorder** (optional) **Substance/Medication-Induced Sleep Disorder** (optional) **ARFID** (optional) Somatic Symptom Disorder (optional) Illness Anxiety Disorder (optional) **Intermittent Explosive Disorder** (optional) **Gambling Disorder** (optional)

6. BASIC FEATURES OF THE SCID-5-RV

6.1 Overview

The SCID begins with an open-ended Overview of the present illness and past episodes of psychopathology before leading the interviewer to systematically inquire about the presence or absence of particular DSM-5 criterion items. This Overview provides opportunities to hear the subject describe any difficulties in his or her own words and to collect information that may not be covered in the course of assessing specific diagnostic criteria (e.g., treatment history, social and occupational functioning, context of developing symptoms). The Overview also includes an assessment of lifetime alcohol and drug use, which serves to make the interviewer aware of the possibility of a substance-induced etiology for psychiatric symptoms that are elicited during the course of the SCID evaluation. The Life Chart, located at the end of the Overview, provides a framework for recording past treatment history in a chronological fashion, which may be useful for subjects with a particularly complex past treatment history. By the end of the Overview, the interviewer should have gathered enough information to formulate a list of tentative diagnoses to be ruled out or substantiated by the diagnostic modules.

6.2 Summary Score Sheet

After the interview is completed, the interviewer fills out the Summary Score Sheet located at the front of the SCID. The instructions for using the Summary Score Sheet are detailed in Section 11.1, "Summary Score Sheet." The SCID-5-RV Summary Score Sheet includes ratings indicating the presence (or absence) of each disorder evaluated. For those disorders that are assessed for both lifetime and current periods, the rating indicates whether the disorder 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. For those disorders that are assessed for only the current period, ratings are provided indicating only whether the disorder has been currently present at a threshold level, at a subthreshold level, or not at all. Disorders that are optional in the SCID are designated both by inclusion of the word "(optional)" as well as gray shading for the rating areas. Upon completing the Summary Score Sheet, the interviewer has the option to indicate which SCID diagnosis is "principal" (i.e., the disorder that is or should be the main focus of current clinical attention), to indicate the interviewer's diagnoses if different from the SCID diagnoses, and finally to indicate "provisional diagnoses" (i.e., those disorders for which more information is needed before they can be ruled out).

The Summary Score Sheet ends with the optional Social and Occupational Functioning Assessment Scale (SOFAS), which was included in DSM-IV-TR Appendix B, "Criteria Sets and Axes Provided for Further Study" (American Psychiatric Association 2000; pp. 817–818). In recognition of how valuable assessing functional impairment can be, the SOFAS has been included as a replacement for the Global Assessment of Functioning (GAF) Scale, which was included on Axis V in DSM-IV and is no longer part of DSM-5. The World Health Organization Disability Assessment Schedule (WHODAS), a 36-item self-report scale included in DSM-5 Section III, "Emerging Measures and Models," is not included in the SCID because of its length, complexity, reliance on self-report, and unclear applicability to individuals with mental disorders. The SOFAS is similar to the GAF Scale in that it is designed to rate social and occupational functioning on a continuum from excellent functioning down to grossly impaired functioning on a 100-point scale represented in 10 deciles; however, the SOFAS differs from the GAF Scale in that the SOFAS focuses exclusively on the individual's level of functioning and is not directly influenced by the overall severity of the individual's psychological symptoms. Also in contrast to the GAF Scale, any impairment in social and occupational functioning that is due to a general medical condition (GMC) is considered in

making the SOFAS rating. The SOFAS is usually used to rate functioning for the current period (i.e., the level of functioning at the time for the evaluation). The SOFAS may also be used to rate functioning for other time periods. For example, for some purposes it may be useful to evaluate functioning for the past year (i.e., the highest level of functioning for at least a few months during the past year). Development of the SOFAS from the GAF Scale is described in Goldman, Skodol, and Lave (1992).

6.3 Diagnostic Flow

The sequence of questions in the SCID is designed to approximate the differential diagnostic process of an experienced clinician. As the interview progresses and the DSM-5 diagnostic criteria embedded in the SCID are assessed, 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-5, but have been reordered to make the SCID interview more efficient or user-friendly. For example, Criterion D for Schizophrenia is listed right after Criterion A 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.

6.4 Ratings

Although specific structured questions are provided to help elicit diagnostic information, it is important to keep in mind the fact that the ratings in the SCID ***reflect the presence or absence of the DSM-5 diagnostic criteria and not necessarily the subject's answers to the SCID questions.*** Ratings in the SCID-5-RV are as follows and are defined further in Section 8.3, "SCID-5-RV Conventions and Usage: Ratings of Criterion Items":

? = Inadequate information to code the criterion as either "1," "2," or "3"
1 = Absent or False
2 = Subthreshold
3 = Threshold or True

Although the majority of the SCID questions can be answered by a simple "YES" or "NO," an unelaborated response of "YES" is rarely enough information to determine whether a criterion is met. Asking the person to elaborate or provide specific examples is usually necessary to make a valid diagnostic rating. For instance, one of the SCID-5-RV questions for an MDE asks whether the individual has had "trouble thinking or concentrating." If the subject answers "YES" to this question, the interviewer must ask follow-up probes (e.g., "What kinds of things do you have trouble concentrating on?") before rating the corresponding criterion as "3" to ensure that the person's experiences match the requirements of corresponding criterion (diminished ability to think or concentrate). Throughout the SCID-5-RV, a rating of "3" should be made only after the interviewer is satisfied that he or she has enough information to determine that the criterion is fully met. Sometimes this entails rephrasing or paraphrasing the wording of the criterion to make the concept clearer to a subject. At other times, the interviewer might find it necessary to seek corroborating information from other sources (e.g., family members, previous records).

Remember that it is not necessary for the subject to acknowledge that the symptom is present to justify a rating of "3" or is absent to justify a rating of "1." (See Section 8.3, "SCID-5-RV Conventions and Usage: Ratings of Criterion Items," in this User's Guide for more information about making ratings.) The rating ultimately depends on the interviewer making a *clinical judgment* as to whether or not a diagnostic criterion is met. If the interviewer is confident that a particular symptom is present despite the subject's

denial of the symptom, the interviewer can gently challenge the subject regarding his or her negative response (e.g., "Although you've told me that you have never heard any voices, I understand from reading the admitting note that you were hearing voices in the emergency room") or even code the symptom as present ("3") if there is enough supporting evidence to do so (e.g., a subject who claims that spending 2 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 absent ("1") or subthreshold ("2").

6.5 Determining Whether a Diagnosis Is "Current"

For most disorders in the SCID, the interviewer assesses whether a diagnosis has ever been present *(lifetime prevalence)* and whether or not there is a *current episode,* which is defined as having symptoms that meet diagnostic criteria during a particular period of time, which extends up to the time of the SCID interview. The designation of the current time frame varies by diagnosis and is determined by the duration and symptom clustering requirements set forth in the DSM-5 criteria (summarized in Table 4). PTSD, for example, which has a required minimum duration of 1 month, uses the past month as the current time frame. Agoraphobia, Social Anxiety Disorder, and Specific Phobia use the past 6 months as the current time frame, given that each of these disorders requires persistence over a 6-month period. Because the symptom clustering time frame in Substance Use Disorders is at least two items over a 12-month period, the prior 12 months is used as the current time frame for Substance Use Disorders. For those diagnoses without a specified duration, the default of 1 month is used as the current time frame. Note that for those disorders that require a duration of symptoms that is less than 1 month (e.g., 2 consecutive weeks for an MDE), the disorder is considered current if the full syndrome extends into the current month (e.g., an MDE that started 5 weeks ago and went into partial remission after only 2 weeks would still be considered current).

Table 4: Time Frames for Considering a Disorder to be Current

Time Frame	Disorders
Past month	Bipolar I Disorder Bipolar II Disorder Major Depressive Disorder Psychotic Disorders (Schizophrenia, Schizophreniform Disorder, Schizoaffective Disorder, Delusional Disorder, Brief Psychotic Disorder) Panic Disorder Obsessive-Compulsive and Related Disorders (Obsessive-Compulsive Disorder, Hoarding Disorder, Body Dysmorphic Disorder, Trichotillomania, Excoriation Disorder) Avoidant/Restrictive Food Intake Disorder Trauma- and Stressor-Related Disorders (Acute Stress Disorder, Posttraumatic Stress Disorder, Adjustment Disorder) Mental Disorders Due to Another Medical Condition (AMC) (Bipolar Disorder Due to AMC, Depressive Disorder Due to AMC, Psychotic Disorder Due to AMC, Anxiety Disorder Due to AMC, Obsessive-Compulsive and Related Disorder Due to AMC)

Table 4: Time Frames for Considering a Disorder to be Current *(continued)*

Past month *(continued)*	Substance/Medication-Induced Disorders (Substance/Medication-Induced Bipolar Disorder, Substance/Medication-Induced Depressive Disorder, Substance/Medication-Induced Psychotic Disorder, Substance/Medication-Induced Anxiety Disorder, Substance/Medication-Induced Obsessive-Compulsive and Related Disorder, Substance/Medication-Induced Sleep Disorder) Other Specified Mental Disorders (Other Specified Bipolar Disorder, Other Specified Depressive Disorder, Other Specified Psychotic Disorder, Other Specified Anxiety Disorder, Other Specified Obsessive-Compulsive and Related Disorder, Other Specified Feeding or Eating Disorder, Other Specified Trauma- and Stressor-Related Disorder)
Past 3 months	Insomnia Disorder Hypersomnolence Disorder Anorexia Nervosa Bulimia Nervosa Binge-Eating Disorder
Past 6 months	Agoraphobia Social Anxiety Disorder Specific Phobia Generalized Anxiety Disorder Separation Anxiety Disorder Somatic Symptom and Related Disorders (Somatic Symptom Disorder, Illness Anxiety Disorder) Attention-Deficit/Hyperactivity Disorder Adjustment Disorder
Past 12 months	Premenstrual Dysphoric Disorder Substance Use Disorders Intermittent Explosive Disorder Gambling Disorder
Past 2 years	Cyclothymic Disorder Persistent Depressive Disorder

Note that the lifetime assessment may come before, after, or in tandem with the current time frame assessment—depending on the logical flow of the questions and the relative advantages of sequential assessment of the complete criteria set for lifetime and current periods versus assessing both lifetime and current periods at the same time for each criterion item. For example, for Substance Use Disorders, it makes the most sense to assess the current time frame (i.e., past 12 months) of Substance Use Disorder symptoms first and to assess the lifetime period only if criteria are not currently met, because repeatedly switching back and forth between an episode of current substance use and past substance use is awkward for both the subject and the interviewer. For Social Anxiety Disorder, on the other hand, it makes the most sense to assess lifetime symptoms of Social Anxiety Disorder first and then to evaluate only certain critical criteria to see if the diagnosis is also current (e.g., that there is marked fear or anxiety about social situations in the past month, that social situations are avoided or else endured with intense anxiety in the past month, and whether the symptoms cause distress or impairment in the past month).

Three different methods are used in the SCID for assessing whether the diagnostic criteria are met for the current time period and during the subject's lifetime:

1. Determining Current After Lifetime: After completing the lifetime assessment of the diagnostic criteria, the presence of the disorder during the "current" time period is then assessed using only selected criteria (i.e., those most relevant to determining whether the disorder should be considered current). This approach is typically used with disorders that have monothetic criteria sets like Agoraphobia and Social Anxiety Disorder which provide a list of lettered criteria, all of which are required for the diagnosis. For example, even though the full Social Anxiety Disorder criteria set has 10 criteria (A–J), only Criterion A (marked anxiety about two or more situations), Criterion D (situations are actively avoided or endured with intense anxiety), and Criterion G (causes clinically significant distress or impairment) are reassessed to determine current Social Anxiety Disorder as illustrated in the example below.

SOCIAL ANXIETY DISORDER CHRONOLOGY

NOTE: IF LIFETIME ASSESSMENT ALREADY SUGGESTS THE PRESENCE OF SOCIAL ANXIETY DISORDER DURING THE PAST 6 MONTHS, ASK THE FOLLOWING QUESTIONS ONLY IF NEEDED.

During the past 6 months, since (6 MONTHS AGO), **have you continued to fear or avoid** (SOCIAL SITUATIONS MENTIONED ABOVE)**?**

A. Marked fear or anxiety about one or more social situations — ? 1 2 3 F79

→ GO TO ***PAST SOCIAL ANXIETY DISORDER*** F.18

During the past 6 months, since (6 MONTHS AGO), **have you gone out of your way to avoid** (FEARED SOCIAL SITUATIONS)**?**

IF NO: **During the past 6 months, since** (6 MONTHS AGO), **how hard has it been for you to be in** (FEARED SOCIAL SITUATIONS)**?**

D. The social situations are avoided or endured with intense fear or anxiety. — ? 1 2 3 F80

→ GO TO ***PAST SOCIAL ANXIETY DISORDER*** F.18

During the past 6 months, what effect has (SOCIAL ANXIETY SXS) **had on your life?**

IF SOCIAL ANXIETY SXS HAVE <u>NOT</u> INTERFERED WITH FUNCTIONING: **During the past 6 months, since** (6 MONTHS AGO), **how much have you been bothered or upset by having** (SOCIAL ANXIETY SXS)**?**

G. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. — ? 1 2 3 F81

→ GO TO ***PAST SOCIAL ANXIETY DISORDER*** F.18

CRITERIA A, D, AND G CODED "3" FOR PAST 6 MONTHS — 1 3 F82

→ GO TO ***PAST SOCIAL ANXIETY DISORDER*** F.18

→ CURRENT SOCIAL ANXIETY DISORDER

2. Determining Lifetime After Current: If a disorder is present currently, it is also considered to be present for the subject's lifetime. Therefore, for some conditions, the assessment of lifetime occurrence is necessary only if criteria are not met for the disorder during the current period. This applies to MDE, Manic Episode, Hypomanic Episode, Persistent Depressive Disorder, Generalized Anxiety Disorder, and Substance Use Disorder. Thus, for these conditions, the entire criteria set is first assessed for the current time frame, and only if the diagnosis was not met during this time frame does the interviewer inquire about past episodes.

3. Determining Lifetime and Current in Tandem. Finally, for some disorders, especially those with complex polythetic criteria sets such as PTSD, in which a subset of criteria are required to make a diagnosis (e.g., at least two out of seven), a third method is used: lifetime occurrence of each item is assessed first, and then for each criterion that is rated "3" for lifetime, the interviewer determines whether or not the criterion has also been present during the current time frame. If this is the case, a second rating of "3" for the past month is given (see example below).

Now I'd like to ask a few questions about specific ways that (TRAUMATIC EVENT) **may have affected you at any time since**

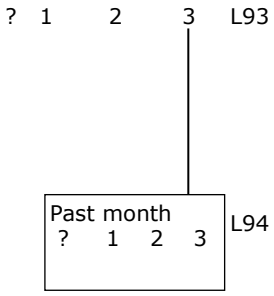
For example, since (TRAUMATIC EVENT)**....**

...have you had memories of (TRAUMATIC EVENT)**, including feelings, physical sensations, sounds, smells, or images, when you didn't expect to or want to? (How often has this happened?)**

IF LIFETIME RATING OF "3": **Has this also happened in the past month, since** (1 MONTH AGO)**? How many times?**

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic events), beginning after the traumatic event(s) occurred

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).



Regardless of the method used for assessing symptoms in current or lifetime periods, given the different time frames that apply to the different disorders, clinical interviewers must take special care to ensure that the subject is focusing his or her attention on the correct time frame.

It should be noted that the following disorders are assessed only for the current period—there is no lifetime assessment:

Cyclothymic Disorder (past ~~1~~2 years~~months~~)
Premenstrual Dysphoric Disorder (past 12 months)
Separation Anxiety Disorder (past 6 months)
Sleep-Wake Disorders (past 3 months)
Avoidant/Restrictive Food Intake Disorder (past month)
Somatic Symptom Disorder (past 6 months)
Attention-Deficit/Hyperactivity Disorder (past 6 months)
Intermittent Explosive Disorder (past 12 months)
Gambling Disorder (past 12 months)
Acute Stress Disorder (past month)
Adjustment Disorder (past 6 months)

6.6 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 gently challenge a subject with discrepancies between his or her account and other sources of information.

If 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 need to be drawn from the medical records or other sources. Before beginning to interview such a subject, the interviewer should review the subject's medical records, note symptoms and dates of prior hospitalizations in the Life Chart (on the last page of the Overview), and record a brief description of the pertinent symptoms in the appropriate section of the SCID-5-RV (e.g., record psychotic symptoms in Module B). In such cases, the SCID-5-RV is not so much an interview guide as a place to systematically record symptoms that have been documented in the patient's records.

7. ADMINISTRATION OF THE SCID-5-RV

Ordinarily, the SCID-5-RV is administered in a single sitting and usually takes from 60 to 120 minutes, depending on the complexity of the psychiatric history and the ability of the subject to describe his or her psychopathology succinctly. Particularly complex cases can take up to 3 hours. In some cases, the SCID-5-RV may need be administered over multiple sittings. If additional information becomes available after the interview is completed, the interviewer should modify the SCID data accordingly.

The SCID has demonstrated good reliability for telephone administration (Crippa et al. 2008; Hajebi et al. 2012; Kendler et al. 1992; Kessler et al. 2004; Lee et al. 2008; Rohde et al. 1997; Sobin et al. 1993). When administering the SCID by telephone, special care must be taken to ensure as best as possible that information that is typically communicated nonverbally is elicited during the telephone interview. For example, while observing facial expressions during a face-to-face interview can yield information about a subject's affect, the interviewer must rely on other nonverbal cues when conducting a telephone interview, such as changes in the speed and tone of the subject's voice, a subject's sniffling, and so forth. Likewise, while interviewers may communicate understanding nonverbally when face-to-face, it is important to verbally demonstrate understanding when conducting a telephone interview (e.g., by pausing, summarizing what you heard, or making empathic statements like "Last month must have been a difficult time for you").

Administration of the SCID by videoconferencing was compared with face-to-face assessment within a rural American Indian community in a study by Shore and colleagues (2007). The study found that SCID assessment by live interactive videoconferencing did not differ significantly from face-to-face assessment.

8. SCID-5-RV CONVENTIONS AND USAGE

Note: It is recommended that you have a copy of the SCID-5-RV in front of you while reviewing the next sections.

8.1 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 (e.g., ***SCHIZOPHRENIA*).** The DSM-5 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 ratings for each criterion. To the far right, in a smaller font, are the field codes. These are provided to facilitate the entering of SCID data into a computerized database. By adopting these field codes as variable names in the computer program, the researcher can more easily compare his or her SCID data with other SCID databases that have been set up using this same naming convention for the field codes. Note that the two versions of Module A (i.e., with specifiers and without specifiers) use the same field codes to refer to the items they share in common. Field codes for the mood specifiers, which are included only in Document 4a (i.e., the version with the specifiers), are numbered separately, starting with AS1, AS2, and so on.

8.2 SCID Questions

8.2.1 Questions asked verbatim

SCID questions not enclosed 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 Module A: "...has there been a period of time when you were feeling depressed or down 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., its duration or persistence for most of the day, nearly every day). 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 2-week period in which you were depressed for most of the day, nearly every day?"

8.2.2 Questions enclosed in parentheses

The SCID convention is that questions in parentheses should be asked when necessary to clarify responses and can be skipped if the interviewer already either knows the answer to the parenthetical question or has sufficient information to rate the criterion as "3." For example, the initial question for the "increase in goal-directed activity" item (Criterion B6) in Manic Episode asks the subject how he or she has spent his or her time. If the subject provides a detailed recounting of behavior that clearly meets this criterion, there is no need to ask the additional parenthetical questions, such as "Were you more

sociable during that time, such as calling on friends, going out with them more than you usually do, or making a lot of new friends?" If, however, the subject's answer to the initial question is not sufficiently detailed to determine whether or not the criterion is met, the interviewer should ask as many of the parenthetical questions as needed to be able to make that rating.

The fact that a question is in parentheses does not imply that the information the question is designed to elicit is any less critical. For instance, the first item in MDE has the inquiry "as long as 2 weeks?" in parentheses. So unless the subject mentions the duration of the depressed mood, the interviewer must ask if it lasted for as long as 2 weeks because the 2-week duration of the depressed mood is a critical requirement for rating this symptom as present.

8.2.3 "OWN WORDS" (and other phrases in all capital letters, such as "AGORAPHOBIC SXS")

Many of the SCID questions contain phrases in all capital letters enclosed in parentheses, such as "(OWN WORDS)," "(AGORAPHOBIC SXS)," and so forth. This convention indicates that the interviewer is to modify the question and insert subject-specific words in place of these designations. For "OWN WORDS," the interviewer should insert the words that the subject has used 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?" For phrases such as "(AGORAPHOBIC SXS)," the interviewer should insert the particular symptoms that the subject has endorsed during the course of the interview. For example, the question corresponding to Criterion G (the clinical significance criterion) for Agoraphobia asks "What effect have (AGORAPHOBIC SXS) had on your life?" In this circumstance, the interviewer should insert the already acknowledged agoraphobic symptoms into the question (e.g., "What effect has not being able to drive across bridges or go into crowded stores had on your life?").

8.2.4 "ONE MONTH AGO" (and other time intervals in all capital letters)

Studies of memory and recall have demonstrated that subjects are more accurate in their recounting of events if questions are anchored to specific past dates as opposed to general time intervals. For this reason, questions inquiring about the presence of a symptom during a particular time interval (e.g., "During the past 6 months,") have been augmented by the phrase "since (SIX MONTHS AGO)," requiring the interviewer to use both the time interval and the exact date in the question. For example, in the determination of whether a lifetime Agoraphobia diagnosis is also current, the question assessing the clinical significance criterion for Agoraphobia is "During the past 6 months, since (SIX MONTHS AGO), what effect have (AGORAPHOBIA SXS) had on your life?" For a SCID interview being done in December, the interviewer would transform this into "During the past 6 months, since this past July, what effect has your inability to go out of the house had on your life?"

8.3 Ratings of Criterion Items

The majority of DSM-5 criteria require that a psychiatric sign, symptom, or finding be present at some sufficient level of severity, persistence, or duration in order to count toward the diagnosis. For such items, the SCID-5-RV offers four possible ratings: "? = inadequate information," "1 = absent," "2 = subthreshold," and "3 = threshold." However, other criteria, such as those invoking diagnostic exclusion rules (e.g., "not better explained by another mental disorder"), as well as algorithmic statements (e.g., "AT LEAST THREE 'A' ITEMS ARE CODED '3'") have only three possible available ratings: "?" for inadequate information, "1 = false," and "3 = true." These SCID-5-RV ratings are explained below:

? = Inadequate information to code the criterion as "1," "2," or "3"
A rating of "?" should be reserved for those situations in which there is insufficient information for a more definitive code for the criterion. For example, in rating the sleep item for a past MDE, a "?" would be appropriate for a subject who cannot remember whether the episode involved disturbed sleep. A rating of "?" may also be temporarily given to indicate uncertainty (e.g., a subject 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 re-rate the criterion, the "?" rating should be crossed out, and a circle drawn around the correct rating. The subsequent information may come from another source, from the subject later in the same interview, or in a subsequent interview. Every effort should be made to resolve these questionable data; however, such as in the example about sleep disturbance in a past MDE above, it may never be possible to obtain the information and in such situations, a rating of "?" would be counted as if the criterion was not met. In some cases, especially for those criteria requiring a "true" or "false" designation, the interviewer will not have sufficient information to make a confident rating either way. For example, the criteria ruling out a substance and general medical etiology—i.e., "the disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition"—requires a dichotomous rating of either "true" or "false." If a potentially etiological substance/medication or GMC is present but the interviewer is unable to confidently determine whether it is in fact the cause of the symptoms, then a rating of "?" may be most appropriate. While in most cases a rating of "?" has the same impact as a rating of "1" (i.e., both lead to the same skip instruction), in some cases the "?" rating has its own skip instruction. For example, for many of the criteria in Module C, Differential Diagnosis of Psychotic Disorders, a rating of "?" leads the interviewer to skip to Other Specified Psychotic Disorder, because this residual category (specifically the "unspecified" variety) is appropriate for situations in which there is insufficient information to make a more precise diagnosis.

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

False: The criterion statement is clearly false (e.g., for a criterion in the form of "the disturbance is not better explained by another mental disorder," a rating of "1" would be used if the interviewer determines that the disturbance is better explained by another mental disorder).

2 = Subthreshold
The threshold for the criterion is almost, but not quite, met (e.g., the subject has been depressed for only 10 days rather than the required 2-week minimum; the subject reports loss of interest in only some activities, but not the required "almost all activities"). This rating does not apply for dichotomous criteria (such as exclusion criteria), in which the criteria must be either "true" or "false" (e.g., the disturbance either is due to a substance/medication or GMC or is not; there is no "in-between" state for such criteria).

3 = Threshold or True
Threshold: The threshold for the criterion is just met (e.g., subject reports being depressed for 2 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").

8.4 Recording Descriptive Information

For most items, the interviewer should ask the subject to provide specific details of thoughts, feelings, and behaviors to support the criterion ratings. This information should be recorded on the SCID in order to document the information 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. In such situations, it is particularly important for the interviewer to record a description of the cognition or behavior solicited from the subject. The interviewer should clearly label information on the SCID that was obtained from sources other than the subject (e.g., charts, informant).

8.5 Diagnostic Flow and Skip-Outs

When moving through the SCID interview, the default rule is always to move to the next item unless otherwise instructed. This each-item-in-turn sequential flow is altered by skip instructions that facilitate skipping over diagnostic criteria that no longer need to be assessed (i.e., because the criteria for the disorder can no longer be met) or are no longer relevant (e.g., skipping the assessment of Persistent Depressive Disorder because criteria are already met for a Manic or Hypomanic Episode).

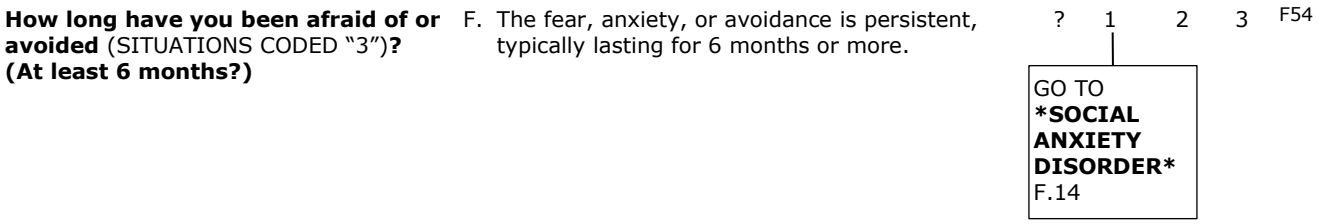
These skip instructions come in three basic formats:

1. 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, Module C (Differential Diagnosis of Psychotic Symptoms) begins with the following instruction:

*IF THERE ARE NO ITEMS CODED "3" IN **B. PSYCHOTIC AND ASSOCIATED SYMPTOMS**, CHECK HERE ___ AND SKIP TO THE NEXT MODULE.*

The interviewer evaluates the conditional statement (i.e., whether there have not been any psychotic symptoms coded "3" in the prior module) and, if true, makes a check mark and continues the SCID with the assessment of the next module (Differential Diagnosis of Mood Disorders).

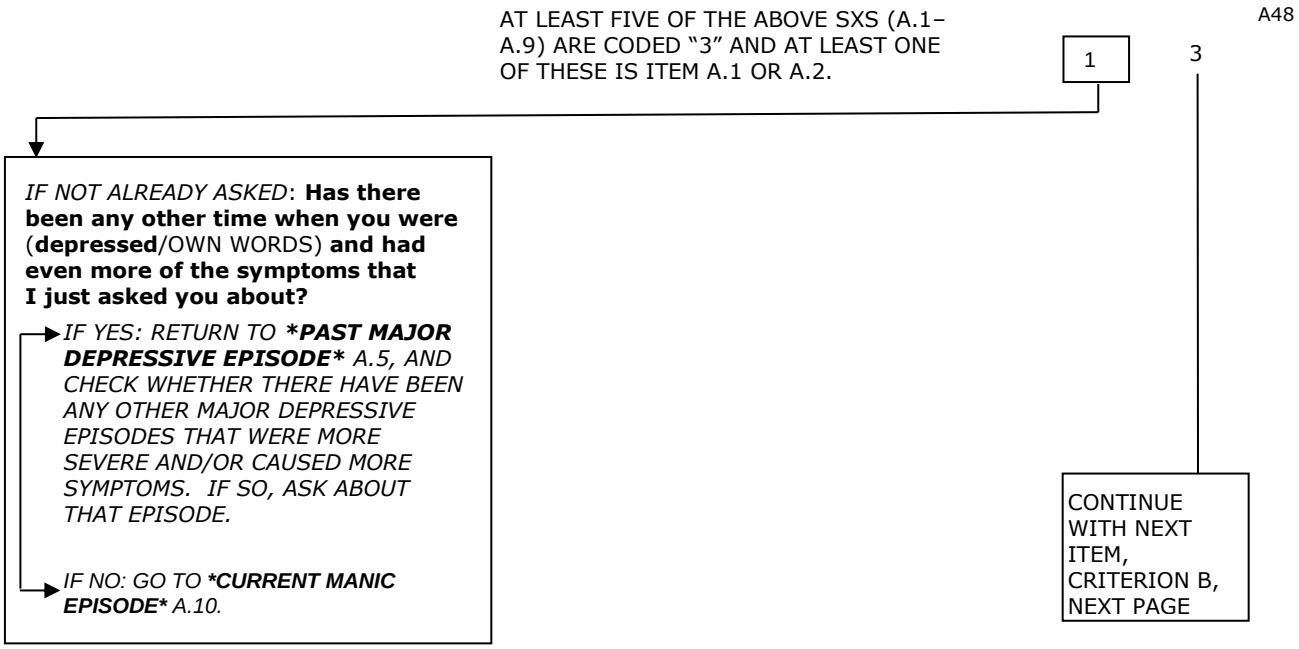
2. Under a Set of Ratings: In these cases, a skip instruction is indicated in the right-hand column where the ratings are made, most typically in a text box hanging down from the rating of "1." This convention is used to enable the interviewer to skip out of a diagnostic section when the criterion being evaluated is judged to be absent or false. The interviewer should follow the vertical line down to the box containing the "GO TO" instruction, which tells the interviewer to skip to the specified page number, look in the left-hand column for the location marker (usually at the top of the page), and continue the interview from that point onward.



In the example above, from page F.10 in the assessment of Agoraphobia, if a rating of "1" is given for Criterion F, the interviewer should skip to page F.14, look for the location marker ***SOCIAL ANXIETY DISORDER*,** and resume asking questions from that point. Note that this does not indicate that the

diagnosis is Social Anxiety Disorder but only directs the interviewer to the assessment of Social Anxiety Disorder. If a rating of "2" or "3" is given, the interviewer should proceed to the next item (i.e., Criterion G in Agoraphobia), 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, rather than having a text box (with a skip instruction) hanging from a rating of "1," there is a vertical and then horizontal line leading to a follow-up question. This mechanism is often used in the assessment of episodic disorders (e.g., lifetime MDEs, Manic Episodes, and Hypomanic Episodes) as a way of having the interviewer consider whether there are episodes other than the one initially selected for evaluation that should be considered once the criteria are not met for the initially selected episode. In the following example from page A.7 in the evaluation of past MDE, if the number of "A" symptoms is below the threshold of five (justifying a rating of "1" on this summary item), the interviewer should follow the line down and then to the left from the "1" rating, leading to the follow-up question about whether there were any other past episodes with even more symptoms.



Much less commonly, a skip instruction can be dependent on the ratings of more than one criterion. For example, the diagnosis of an MDE requires the presence of either depressed mood (Criterion A1) or loss of interest or pleasure (Criterion A2); thus, both of these ratings must be considered during the instruction to skip out of the assessment of the depressive episode. This combined skip instruction (as shown on the next page) is indicated by vertical lines 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.5," indicating that the interviewer should skip to page A.5 for the past MDE section only if **both** of these criteria are judged not present (i.e., are coded "1" or "2").

Now I am going to ask you some more questions about your mood.

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood, or (2) loss of interest or pleasure.

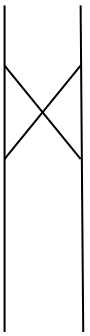
Since (1 MONTH AGO)**, has there been a period of time when you were feeling depressed or down <u>most of the day nearly every day</u>? (Has anyone said that you look sad, down, or depressed?)**

IF NO: **What about feeling empty or hopeless most of the day nearly every day?**

IF YES TO EITHER OF ABOVE: **What has that been like? How long has it lasted? (As long as 2 weeks?)**

1. Depressed mood most of the day, nearly every day, as indicated either by subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). NOTE: in children or adolescents, can be irritable mood.

? 1 2 3 A1



IF PREVIOUS ITEM CODED "3:" **During that time, did you lose interest or pleasure in things you usually enjoyed? (What has that been like? Give me some examples.)**

IF PREVIOUS ITEM NOT CODED "3:" **What about a time since** (1 MONTH AGO) **when you lost interest or pleasure in things you usually enjoyed? (What has that been like? Give me some examples.)**

IF YES: **Has it been nearly every day? How long has it lasted? (As long as 2 weeks?)**

2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated either by subjective account or observation).

? 1 2 2 A2

IF NEITHER ITEM A.1 NOR A.2 IS CODED "3," GO TO ***PAST MAJOR DEPRESSIVE EPISODE*** A.5

3. As an "Either/Or" Decision in the Middle of the Assessment of a Disorder: Skip-outs are sometimes indicated by capitalized instructions in the middle of a diagnostic assessment of a disorder, and may be in "either/or" terms. For example, in the assessment of OCD, the instruction on the top of page G.3, which occurs after the assessment for the presence of either obsessions or compulsions, states

IF EITHER OBSESSIONS OR COMPULSIONS, OR BOTH, CONTINUE BELOW.

IF <u>NEITHER</u> OBSESSIONS <u>NOR</u> COMPULSIONS, CHECK HERE ___ AND GO TO ****OTHER SPECIFIED OC AND RELATED DISORDER**** *G.8 <u>OR</u>* ****HOARDING DISORDER (OPTIONAL)**** *Opt-G.1.* G9

In this case, on the basis of the assessment on the prior two pages, the interviewer considers whether there have been either obsessions or compulsions. If either has been present, the interviewer continues with the next item.

Always be on the lookout for skip instructions. When there is no skip instruction, the rule is to proceed to the next item.

8.6 Multiple Clauses in Criterion Sets

Many of the diagnostic criteria in DSM-5 contain multiple clauses that are joined by "OR" (e.g., there is a persistent desire OR unsuccessful efforts to cut down or control alcohol use). A rating of "3" for the criterion is made if ANY of the clauses are judged to be present. Typically there are multiple SCID questions for such criterion, with subsequent questions after the initial question preceded by "IF NO." Therefore, in order to maximize interviewing efficiency, the interviewer only needs to ask the additional questions if the rating corresponding to the first part of the criterion is rated as absent ("1"). The interviewer can stop asking questions if the part of the diagnostic criterion corresponding to the initial question is present at a threshold level ("3"). In the example below from page E.1, Substance Use Disorders, if the subject answers "YES" to the first question and provides supporting examples, the item can be rated "3" without the interviewer having to ask about whether the subject was drinking for a longer period of time than intended.

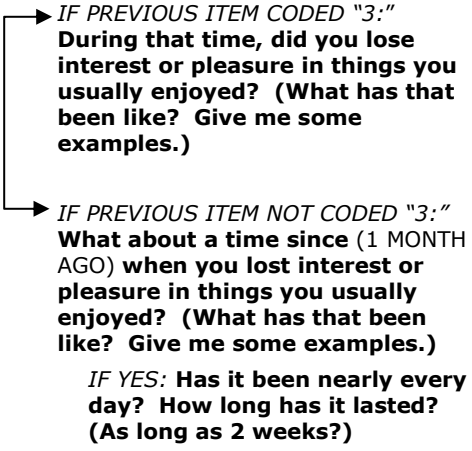
During the past year, have you found that once you started drinking you ended up drinking much more than you <u>intended</u> to? For example, you planned to have only one or two drinks but you ended up having many more. (Tell me about that. How often did this happen?) *IF NO:* **What about drinking for a much longer period of time than you were <u>intending</u> to?**	1. Alcohol is often taken in larger amounts OR over a longer period than was intended.	?	1	2	3	E2

Note that for some criteria, particularly those in which *each* of the subcomponents of the criterion is of clinical importance (e.g., those in the MDE criteria set), the interviewer must ask all of the questions corresponding to the components of the criterion regardless of whether the question corresponding to the initial part of the criterion is answered "YES" or "NO." For example, although Criterion A7 of MDE (see below, from page A.2) requires feelings of worthlessness OR excessive or inappropriate guilt, questions are provided to assess both of these components because of the clinical importance of both of these symptoms. Whether worthlessness, inappropriate guilt, or both have been present is noted by making the appropriate check marks below the criterion.

...have you been feeling worthless? **What about feeling guilty about things you have done or not done?** *IF YES*: **What things? (Is this only because you can't take care of things since you have been sick?)** *IF YES TO EITHER OF ABOVE:* **<u>Nearly every day?</u>**	7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick) *Check if*: _____ worthlessness _____ inappropriate guilt	?	1	2	3	A13 A14 A15

8.7 Brackets Indicating Mutually Exclusive 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 capitalized conditional statements to see which of the two questions applies. For example, in the assessment of current MDE (page A.1), the question for the loss of interest item (Criterion A2) begins with the following pair of mutually exclusive questions:



2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated either by subjective account or observation).

In this case, the selection of the particular version of the loss of interest question depends on the rating given to the Criterion A1 depressed mood item. If the depressed mood item is rated "3," the first selection ("IF PREVIOUS ITEM CODED '3:'") is made (i.e., determining whether or not there was loss of interest during the time of the 2 weeks of depressed mood). If the rating for the depressed mood item is not a "3," (indicating that there was no 2-week period of depressed mood), then the alternative version of the loss of interest question ("IF PREVIOUS ITEM NOT CODED '3:'") should be asked, establishing whether or not there was a 2-week period of diminished interest or pleasure during the past month.

8.8 Due to General Medical Condition, Substance/Medication-Induced, or Primary

Most of the diagnoses covered in the SCID include a criterion that requires the interviewer to decide whether or not the psychopathology is caused by the direct effects of a GMC or substance/medication use on the central nervous system (i.e., "the disturbance is not due to the direct physiological effects of a substance/medication or another medical condition"). If the interviewer determines that the disturbance is <u>not</u> due to the direct physiological effects of a GMC or substance/medication use, the symptoms are considered to be **primary** and the interviewer continues to the next item (which most typically results in making the diagnosis since the "organic rule-out" criterion is usually the last item in the criteria set). If, instead, the interviewer judges that the symptoms are in fact due to the direct effects of a GMC or substance/medication use, then the interviewer is instructed to skip out of the evaluation and instead diagnose the appropriate mental disorder due to another medical condition (AMC) or substance-induced disorder. Note that throughout the SCID-5, the DSM-IV term *general medical condition* has been retained to refer to nonpsychiatric medical conditions instead of the DSM-5 term *another medical condition.* The GMC term was chosen to prevent any confusion that may arise from the fact that "another medical condition" could be interpreted to include psychiatric conditions as

well as medical conditions. A psychiatric disorder is in fact an AMC, as per the DSM-5 perspective that considers all psychiatric disorders to be medical conditions. The term "another medical condition" is used in the SCID-5 only when referring to the name of a DSM-5 disorder (e.g., Depressive Disorder Due to Another Medical Condition) or when it appears within a DSM-5 diagnostic criterion—e.g., "the episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, medication) or to another medical condition."

For example, in evaluating the criteria for an MDE, on page A.4 the interviewer comes to Criterion C ("not due to the direct physiological effects of a substance, medication or to another medical condition)." If the interviewer decides that the depression is secondary to a substance (e.g., cocaine), then a diagnosis of Cocaine-Induced Depressive Disorder is made. On the other hand, if the interviewer decides that the depression is primary (or independent of the substance/medication or the GMC), the interviewer continues with the next item right below (i.e., "MAJOR DEPRESSIVE EPISODE CRITERIA A, B, AND C ARE CODED "3").

NEOPHYTE SCIDers 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/medication or GMC (i.e., it is primary)—say to yourself, "YES ('3'), there is no substance/medication or GMC that is causing the psychiatric symptoms (or, to recall that chestnut from the 1920s, "Yes, we have no bananas!"). The criterion is **NOT MET** (coded "1") if it is **NOT TRUE** that the disturbance is not due to a substance/medication or GMC—say to yourself "NO ('1'), there is a substance/medication or a GMC that is causing the psychiatric symptoms." Another approach to understanding this convention is to remember that a code of "1" also means "False; thus, the statement that the disturbance is not due to something is False.

More specific instructions for determining whether a disturbance is due to a GMC, is substance/ medication-induced, or is primary are found in Section 10, "Differentiating General Medical and Substance/Medication Etiologies From Primary Disorders."

8.9 Consideration of Treatment Effects

Symptoms should be coded as present or absent without any assumptions about what would have been present if the subject were not receiving treatment. Thus, if a patient is taking 12 mg/day of risperidone 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 hypnotic medication every night and no longer has problems sleeping, insomnia should be coded as currently absent ("1").

8.10 Clinical Significance

Most disorders in the SCID-5 include a criterion that requires there to be clinically significant distress or impairment before a DSM-5 diagnosis can be made. Note that there are two components, distress and impairment, either of which indicate clinical significance. It is usually more straightforward to determine what is clinically significant impairment rather than clinically significant distress; therefore, the SCID-5 impairment questions come first. Distress only needs to be assessed in rare circumstances in which there is distress without any impairment. The corresponding SCID-5 questions focus on the degree to which the symptoms have had an impact on the subject's life. A number of optional questions are included for each of these clinical significance evaluations to assess the impact on work and school

functioning, social functioning, leisure activities, and other areas of functioning. DSM-5 does not provide any guidelines as to how much impairment is needed to be considered "clinically significant"—leaving it to the clinical judgment of the interviewer. Certainly, seeking treatment is evidence of clinically significant distress or impairment, but even that rule of thumb may not be helpful in determining whether comorbid symptoms that are uncovered during the evaluation process should be considered clinically significant. It is often helpful to think of the "distress" component in terms of how much the person is bothered by the fact that he or she has the symptoms.

8.11 Use of the Screening Module

Following the SCID-5-RV Overview, the interviewer has the option of administering a Screening Module. It consists of screening questions that can be asked of the subject for the disorders in the Anxiety Disorders, Obsessive-Compulsive and Related Disorders, Sleep-Wake Disorders (only if this optional module is being assessed), Feeding and Eating Disorders, Somatic Symptom and Related Disorders (only if this optional module is being assessed), and Externalizing Disorders modules. See Section 11.3, "Screening Module," in this User's Guide for more instructions.

Each question in the Screening Module is keyed to particular DSM-5 criterion items throughout the remainder of the SCID-5-RV. A "NO" answer to a screening question allows the interviewer to skip the assessment of the corresponding disorder, hence its role as a "screener." A "YES" answer to a screening question requires the interviewer to paraphrase the question at the starting point of the assessment of the corresponding disorder in the SCID-5-RV (e.g., "You've said that you have had an intense rush of anxiety, or what someone might call a 'panic attack,' when you suddenly felt very frightened or anxious, or suddenly developed a lot of physical symptoms") and to continue with a request for details as provided in the follow-up questions. If the interviewer decides not to use the Screening Module, then when assessing the disorder the interviewer simply asks the questions included in the Screening Module for the first time during the course of the SCID interview (e.g., the interviewer begins the assessment of Panic Disorder on page F.1 by asking, "Have you ever had an intense rush of anxiety, or what someone might call a 'panic attack,' when you suddenly felt very frightened or anxious, or suddenly developed a lot of physical symptoms?").

Administering these screening questions at the beginning of the SCID may help reduce the risk of a "negative response bias" that may occur during the course of SCID-5-RV administration, especially in the Anxiety Disorders and later sections. In these sections, the assessment of each disorder begins with a question that if answered in the negative, triggers a skip to the assessment of the next disorder. Once it becomes evident that a "YES" answer to the initial probe question results in additional follow-up questions—whereas a "NO" answer results in a skip to the next section, some subjects may start giving "NO" answers to the questions (i.e., false negatives) in order to speed the interview along. Asking these screening questions up front before the impact of answering "NO" becomes apparent to the subject may minimize the negative reporting bias. Another advantage of using the Screening Module is that it provides a quick preview of the extent of acknowledged psychopathology, which may be helpful in pacing the SCID interview. For example, if during the administration of the Screening Module the subject provides affirmative answers to most of the screening questions, this may indicate that the amount of time allocated to complete the interview may be insufficient and thus require the scheduling of a follow-up session to complete the entire SCID.

There are, by necessity, two versions of the Screening Module. The standard version (with 15 questions) screens for only the core SCID disorders, whereas the enhanced version (30 questions) includes screening questions for both the core and optional disorders. Note that even if you are using only the

core SCID version, which does not include a full diagnostic assessment of the optional disorders, it may nonetheless be advantageous to administer the version of the Screening Module that includes the screening questions for the optional disorders. The interviewer would then have the option to assess these positively screened optional disorders more comprehensively in a follow-up unstructured interview.

8.12 Inclusion of Field Codes in Right-Hand Column

The far right-hand column of the SCID includes consecutively numbered field codes, one for each rated entity in the SCID. These include ratings of individual criterion items, ratings of subtypes and specifiers, and indicators that a section of the SCID has been appropriately skipped (e.g., a field corresponding to the check mark for statements such as "check here ___ and skip to the next module"). Although the primary purpose of the field codes is to provide a standardized way of referring to SCID data items to facilitate comparison of SCID results from different studies, these field codes are also useful in SCID supervision for referring to individual rated items during discussion of the ratings.

8.13 Specified and Unspecified Disorders in the SCID-5

DSM-5 replaced the DSM-IV Not Otherwise Specified (NOS) designation with two options for clinical use: Other Specified Disorder and Unspecified Disorder. According to DSM-5 (pp. 15–16)—

> The Other Specified Disorder category is provided to allow the clinician to communicate the specific reason that the presentation does not meet the criteria for any specific category within a diagnostic class. This is done by recording the name of the category, followed by the specific reason. For example, for an individual with clinically significant depressive symptoms lasting 4 weeks but whose symptomatology falls short of the diagnostic threshold for a major depressive episode, the clinician would record "other specified depressive disorder, depressive episode with insufficient symptoms." If the clinician chooses not to specify the reason that the criteria are not met for a specific disorder, then "unspecified depressive disorder" would be diagnosed.

The SCID-5 includes seven Other Specified categories: Other Specified Psychotic Disorder, Other Specified Bipolar Disorder, Other Specified Depressive Disorder, Other Specified Anxiety Disorder, Other Specified Obsessive-Compulsive and Related Disorder, Other Specified Feeding or Eating Disorder, and Other Specified Trauma- and Stressor-Related Disorder. Subtypes are provided for each of these Other Specified Disorders that correspond to the "examples of presentations that can be specified using the 'other specified' designation" mentioned in the DSM-5 text for each of the Other Specified categories. For example, the third example of a presentation listed in Other Specified Depressive Disorder is "depressive episode with insufficient symptoms" (DSM-5, pp. 183–184). The corresponding third "subtype" of Other Specified Depressive Disorder on D.13 of the SCID-5 is also "depressive episode with insufficient symptoms." Each of the Other Specified Disorder categories in the SCID-5 also include an "Other type" and an "Unspecified type." The "Other" type allows the interviewer to record the reason that the presentation does not meet the criteria for any of the specified disorders, as is allowed in DSM-5. The SCID-5 does not include any of the DSM-5 Unspecified Disorders. Instead, each of the Other Specified Disorders offers the option of an "Unspecified type," which can be used for those situations that would justify use of the Unspecified Disorder diagnosis in DSM-5, such as "presentations in which there is insufficient information to make a more specific diagnosis (e.g., in emergency room settings)" (DSM-5, p. 122).

8.14 Deviations From DSM-5 Criteria

The middle column in the SCID generally contains the DSM-5 criteria reprinted verbatim. There are several circumstances in which the diagnostic criteria deviate from the verbatim DSM-5. In the course of revising the SCID, we discovered several apparent errors and ambiguities in the DSM-5 criteria and inconsistencies between the DSM-5 criteria and the accompanying explanatory text. In such situations, after consulting with members of the DSM-5 Work Groups in order to confirm that these were in fact errors and to arrive at the best solution, we made changes in the DSM-5 criteria sets to reflect the outcome of these discussions. In other cases, changes have been made to enhance the SCID interview. For example, the illustrative examples that accompanied the DSM-IV criteria for Substance Dependence and Abuse that were omitted from DSM-5 have been included in the SCID. An explanation of these adjustments to the DSM-5 criteria wording and the rationale for our corrections is included in the annotations of the individual criteria in Section 11, "Special Instructions for Individual Modules."

Whenever the DSM-5 criteria in the SCID differ from what is in the official DSM-5, we have noted the changes by bracketing the text:

- Phrases <u>added</u> to the DSM-5 diagnostic criteria are enclosed in brackets—e.g., Criterion J in Social Anxiety Disorder: "If another medical condition (e.g., Parkinson's disease, obesity, disfigurement from burns or injury) [or potentially embarrassing mental disorder] is present, the fear, anxiety, or avoidance is clearly unrelated or is excessive."
- Words that have been <u>omitted</u> are indicated with bracketed ellipses (e.g., Criterion A for Manic Episode, in which the words "goal-directed" are omitted: "A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased […] activity or energy").

For editorial reasons, we retained the DSM-IV convention of capitalizing disorder and specifier names so as to more clearly set these diagnostic constructs apart from the rest of the text. For similar reasons, we retained the DSM-IV term "general medical condition" (GMC) throughout the SCID instructions to refer to medical conditions listed outside of the mental disorders chapter in ICD, rather than use the DSM-5 term "another medical condition" (AMC). However, we retained the use of "another medical condition" when it appears within a DSM-5 diagnostic criterion and when it occurs as part of the name of the disorder (e.g., the SCID Summary Score Sheet refers to "Depressive Disorder Due To Another Medical Condition").

9. SCID DO'S AND DON'TS

DO	***DON'T***
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 the questions you are asking or the length of the interview. Most subjects appreciate the thoroughness of the SCID and welcome the opportunity to describe their symptoms in detail.
DO use the Overview to establish rapport and set the tone for the interview. Be present with the subject, demonstrating a nonjudgmental stance while showing appropriate professionalism and boundaries.	***DON'T*** let challenging respondents take control of the interview: • ***DON'T*** let respondents be unnecessarily tangential. Redirect subjects who are providing information that is unnecessary for completing a diagnostic interview. • ***DON'T*** be defensive with respondents who are angry or hostile. Use reflective statements to demonstrate empathy. ***DON'T*** ignore a subject's reports of suffering. Demonstrate empathy while maintaining an objective stance.
DO use the Overview to collect information about the subject's symptoms and functioning to inform the questions you'll ask in the diagnostic modules. (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 detailed questions 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 use open-ended questions to capture the subject's perceptions of the problem in his or her own words.	***DON'T*** ask leading questions. Keep an open mind about hypotheses. Use closed-ended questions sparingly.
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. Great care was taken in crafting the exact phrasing of each question, and the questions work in nearly all cases.

DO	***DON'T***
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 pay attention to consistency in subjects' reports and what is known about the symptoms. ***DO*** gently challenge discrepancies.	***DON'T*** be afraid of offending the subject by asking more follow-up questions. In fact, when you seek to clarify responses, subjects may be more likely to feel that they are being truly heard.
DO make diagnoses according to the DSM-5 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). At a minimum, put a checkmark in the indicated spot (in the skip instruction) to show that you skipped out intentionally.
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 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 2-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 a "YES" or "NO" answer to the SCID question.
DO give the subject the benefit of any doubt about a questionable psychotic symptom by rating either "1" (absent or false) or "2" (subthreshold).	***DON'T*** call a subculturally accepted religious belief or an overvalued idea a delusion. ***DON'T*** confuse ruminations or obsessions with auditory hallucinations.

DO	***DON'T***
DO make sure that each symptom noted as present is diagnostically significant.	***DON'T*** assume that a symptom is diagnostically significant just because it is endorsed. For example, if a subject says that YES, he had trouble sleeping, but 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 an MDE unless the sleep problem was worse during the period under review. This is particularly important when an episodic condition (such as an MDE) is superimposed on a chronic condition (such as Persistent Depressive Disorder).
DO pay attention to double negatives, especially in the exclusion criteria. Remember to use the phrase "Yes, we have no bananas" to help guide you if you get confused about how you should rate one of these criteria. For example, if the subject denies using drugs or medications or being ill during the onset of a condition, that item should be rated "3" (i.e., "YES, it is true that no medical condition or substance use is causing the disturbance").	***DON'T*** code "1" for an exclusion criterion requiring the absence of an etiological factor when you mean to indicate that the excluded etiological factor is NOT present (and thus the criterion should be coded a "3"). For example, if the criterion reads "NOT attributable to the direct physiological effects of another medical condition or substance/medication use," then a rating of "1" means that the disturbance is secondary (i.e., due to a general medical condition or substance/medication), and a rating of "3" means primary (i.e., NOT due to a general medical condition or substance/medication).

10. DIFFERENTIATING GENERAL MEDICAL AND SUBSTANCE/MEDICATION ETIOLOGIES FROM PRIMARY DISORDERS

This section describes the process of evaluating the "organic rule-out" criterion that is included in the diagnostic criteria for the majority of the disorders assessed in the SCID, usually as one of the last items in each diagnostic criteria set. This criterion occurs typically in the following form: "The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition." The first consideration when evaluating this criterion is whether, ***at the time of onset or worsening of the symptoms***, the subject was physically ill with a medical condition (either acute or chronic), taking a medication, or using significant amounts of alcohol or a drug of abuse. Consequently, the SCID questions that correspond to this criterion include: "Just before this began, were you physically ill?" "Just before this began, were you using any medications?" and "Just before this began, were you drinking or using any drugs?" If there is no medical illness, medication use, or substance use coincident with the onset or worsening of the symptoms (i.e., the answers to these three questions are "NO"), then this criterion is automatically fulfilled and the interviewer can give a "3" rating for the item, indicating that the disturbance is primary. It is important to understand that the time frame of inquiry is NOT necessarily the artificially restricted period of time being focused on in the diagnostic assessment (e.g., worst 2 weeks in the past month for a potential current MDE or worst week of a potential past Manic Episode), but rather the point in time when the symptoms began or significantly worsened. It is therefore crucial at this point in the SCID to know when the symptomatic period began. For that reason, the three questions noted above are preceded by the question: "IF UNKNOWN: When did this period of [SXS] begin?"

The next consideration is whether or not the medical illness, medication, or drug of abuse has the potential to cause the symptoms in question. To assist the interviewer in making this determination, a list of symptom-specific "etiological medical conditions" and "etiological substances/medications," which were adapted for the most part from the DSM-5 text, are included with the criterion.[1]

If there is any suspicion based on the timing and known potential of the possible etiological factor that it may have caused the symptoms, the interviewer is instructed to skip to the ***GMC/SUBSTANCE*** section at the end of the module in order to evaluate the diagnostic criteria for the appropriate Mental Disorder Due to Another Medical Condition and Substance/Medication-Induced Mental Disorder. If the criteria for one or both of these conditions are met, then the interviewer jumps back to the organic rule-out criterion and codes a "1," indicating that in fact the symptoms ***were*** attributable to a GMC or substance/medication (i.e., that the symptoms were **not** primary) and the evaluation for the presence of the primary disorder should be ended.

For example, consider the evaluation of a subject with recurrent, unexpected panic attacks. Panic Disorder Criterion C (page F.4) involves consideration of whether the panic attacks are attributable to the physiological effects of a GMC or substance/medication. If the interviewer were to discover that the panic attacks seem to occur only during periods of heavy coffee use, the interviewer would jump first to page F.33 (i.e., the beginning of the evaluation of Anxiety Disorder Due to Another Medical Condition)

[1] The DSM-5 text for Bipolar Disorders did not provide such a list, and we would like to thank Ariel Gildengers, M.D., and Antoine Doualhy, M.D., at the University of Pittsburgh Medical Center for their assistance with this list.

and then, because the attacks are not associated temporally with a GMC, skip to page F.35 to consider whether Caffeine-Induced Anxiety Disorder accounts for the panic 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 ("1") and skip to Agoraphobia (page F.8). Otherwise, if the panic attacks are considered to be primary (i.e., in the absence of a GMC or substance/medication etiology), the interviewer continues with Criterion D for Panic Disorder on page F.4.

If information from the Overview suggests that the diagnosis of Panic Disorder is likely to be excluded because of an etiological GMC or substance/medication use, the interviewer may skip directly to the ratings for Anxiety Disorder Due to Another Medical Condition (page F.33) or Substance/Medication-Induced Anxiety Disorder (page F.35), rather than spending time documenting an apparent primary syndrome that ultimately is going to be excluded on the basis of a GMC or substance/medication etiology.

It should be noted that the evidence available to determine whether psychiatric symptoms are best considered primary or due to a GMC or substance/medication is often insufficient to allow the interviewer to make a confident judgment. To help the interviewer deal with such cases, we recommend that investigators in a particular study establish a "study-wide policy" regarding the threshold of evidence required to justify a decision that the GMC or substance/medication use is etiological. Given that a Mental Disorder Due to Another Medical Condition is relatively rare, for most studies, it probably makes sense to maintain a relatively high threshold for making this diagnosis (i.e., when in doubt, do not diagnose "…Disorder Due to Another Medical Condition"). However, in those studies in which it is particularly important to screen out possible etiological GMCs or substances/medications, it may make sense to establish a very low threshold to screen out individuals who report any possible associated GMCs or substances/medications.

Given that the procedure for determining whether a GMC or substance/medication is etiological depends on the assessment of the diagnostic criteria for the corresponding Mental Disorder Due to Another Medical Condition and Substance/Medication-Induced Mental Disorder, in the next two sections below, we provide instructions for applying these diagnostic criteria.

10.1 Assessing Disorders Due to a General Medical Condition

Criterion A—Symptoms characteristic of the disorder predominate the clinical picture: This criterion identifies the symptomatic nature of the psychiatric presentation and is essentially automatically coded "3," given that the interviewer has reached this criteria set by virtue of skipping out of the diagnostic evaluation of a primary disorder with those symptomatic features (e.g., the evaluation of Anxiety Disorder Due to Another Medical Condition occurs after the interviewer has already provided ratings of "3" for anxiety symptoms that are clinically significant).

Criteria B/C—Evidence from the history, physical examination, or laboratory findings that the disturbance is the direct pathophysiological consequence of another medical condition and not better accounted for by another mental disorder: The SCID-5 combines these two criteria into one, because the process for determining that the disturbance is the direct physiological consequence of a GMC is inextricably linked with ruling out other explanations for the symptomatology.

The first part of this criterion indicates that there must be some evidence from the history, physical examination, or laboratory findings that the subject has a medical condition that has been shown in the literature to cause the psychiatric symptoms in question. As noted above, for each class of symptoms, the SCID provides a list of possibly etiological GMCs below the criterion in the primary disorder in which the interviewer is asked to rule out the etiological GMC. Once the presence of a candidate medical condition is established, the next step is to determine whether there is a close temporal relationship between the course of the psychiatric symptoms and the course of the GMC. For example, did the psychiatric symptoms start after the onset of the GMC, get better or get worse with the waxing and waning of the GMC, and remit when the GMC has resolved? The questions provided in the left-hand column of the SCID address these relationships. The more of these relationships that can be demonstrated, the more compelling a case can be made that there is a causal connection between the psychiatric symptoms and the GMC.

Note that demonstrating 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. For example, depression occurring immediately after a paralyzing stroke could reflect damage to underlying brain structures responsible for regulating mood (causality at a physiological level) or may be a psychological reaction to the devastating loss of the ability to move a part of the body (causality at a psychological level). Furthermore, the lack of a temporal relationship does not necessarily rule out causality. In some instances, psychiatric symptoms may be the first harbinger of another medical condition and may precede by months or years any physical manifestations (e.g., hypothyroidism, low testosterone, brain tumor). Conversely, psychiatric symptoms may be a relatively late manifestation, occurring months or years following the onset of another medical condition (e.g., depression in Parkinson's disease).

Another factor that may suggest an etiological relationship between the GMC and the psychiatric symptoms is atypicality in symptom presentation. For example, severe weight loss in the face of a relatively mild depression—or the first onset of mania in an elderly patient—is an unusual presentation and should alert the clinician to the possibility that a comorbid GMC is the cause. It should be acknowledged, however, that atypicality is not necessarily compelling evidence; by their very nature, psychiatric presentations are quite heterogeneous within a particular diagnosis.

Finally, it is important to consider whether a primary or substance-induced disorder best explains the symptoms. Are the psychiatric symptoms best explained as a psychological reaction to the stressor of having the GMC (in which case the diagnosis of Adjustment Disorder would be more appropriate)? Has the individual had prior episodes of the same type of psychiatric symptoms that were not due to a GMC (e.g., past recurrent depressive episodes)? Is the person abusing a substance or taking a medication that is known to cause the psychiatric symptoms? Does the subject have a strong family history for the disorder in question?

Note that the diagnoses that are "…Due to Another Medical Condition" are relatively rare. Much more common are the situations in which psychiatric symptoms are comorbid with a GMC (e.g., depression and heart disease). Therefore, when in doubt, the interviewer's default position should be to assume that a GMC is NOT etiological (i.e., the psychiatric disorder is primary).

Criterion E—Clinical significance: The clinical significance criterion for most disorders emphasizes the requirement that a symptom pattern must lead to impairment or distress before being considered diagnosable as a mental disorder. This criterion may help the interviewer make a decision as to whether

a diagnosis should be made, particularly in studies of nonpatients for whom the severity of the presentation is near the symptomatic threshold for a disorder.

10.2 Assessing Substance/Medication-Induced Disorders

In DSM-5, the term "substance/medication use" includes the use of illicit drugs and prescribed or over-the-counter medication. When substance/medication use and psychiatric symptoms co-occur, there are three possibilities as to the nature of their relationship with each other:

1) The psychiatric symptoms may be a direct physiological consequence of the substance use (e.g., Cocaine-Induced Depressive Disorder, With Onset During Withdrawal).

2) The substance use may be a manifestation of the psychiatric disorder (e.g., cocaine use to self-medicate an underlying depressive disorder).

3) The psychiatric symptoms and the substance use may be coincidental.

The ratings for a Substance/Medication-Induced Disorder involve differentiating the first type of causal connection from the other two scenarios. Substance/Medication-Induced Disorders in DSM-5 generally follow this set of criteria:

Criterion A—Symptoms characteristic of the disorder predominate the clinical picture: This criterion is included for completeness and is essentially automatically coded "3" (i.e., you would only be assessing this particular criterion if there is a psychiatric disturbance that you suspect is due to a substance/medication).

Criterion B—Evidence from the history, physical examination, or laboratory findings that 1) the symptoms developed during or soon after substance intoxication or withdrawal or use of medication and 2) the involved substance is capable of producing the symptoms: This criterion establishes both the temporal relationship between substance/medication use and the development of the psychiatric symptoms and that the substance/medication use, at the dose and duration used by the subject, is sufficient to credibly cause the psychiatric symptoms. Criterion B1 pertains to the symptoms in Criterion A developing during or soon after substance intoxication or withdrawal or after exposure to a medication, whereas Criterion B2 pertains to the requirement that the substance/medication is capable of producing the symptoms in Criterion A. For drugs of abuse, this criterion establishes that the psychiatric symptoms occur in the context of intoxication or withdrawal, thereby implying that enough of the substance was used to have caused intoxication or withdrawal. As noted above, the SCID-5 provides for each class of symptoms a list of possibly etiological substance classes and types of medication. For the substance classes, there is an additional designation indicating whether the symptoms can arise during intoxication "(I)"; during withdrawal "(W)"; or either "(I/W)."

Criterion C—Symptoms are not better accounted for by a disorder that is not substance/medication induced: Given that Criterion B has established a temporal relationship between the *onset* of the psychiatric symptoms and substance use, this criterion establishes an etiological connection between the substance/medication and the psychiatric symptoms by ruling out other non-substance-related explanations that could better account for the psychiatric symptoms.

Three guidelines for evaluating this criterion (with corresponding interview questions) are provided for determining whether there is evidence that the symptoms are not substance/medication-induced:

1) *Is there evidence that the psychiatric symptoms were present immediately before the onset of the substance/medication use?* A definite history of the psychiatric symptoms occurring before the course of substance or medication use suggests a self-medication scenario and strongly supports the hypothesis that the symptoms cannot be explained by substance use.

2) *Do the psychiatric symptoms persist, even after a substantial period of abstinence (e.g., about 1 month)?* If the symptoms were caused by the substance/medication use, then one would expect that the symptoms would remit after the acute effects of intoxication and withdrawal subside. If the symptoms continue to persist long after the substance/medication use ends, the duration suggests instead that the symptoms represent a primary mental disorder (or perhaps a Mental Disorder Due to Another Medical Condition). Note that the 1-month period provided in the DSM-5 criterion should be considered only as a loose guideline. The actual amount of time of abstinence that would be required before concluding that the psychiatric symptoms are primary depends on many factors, including the particular substance/medication used, dosage, and half-life.

3) *Is there any other evidence that is more supportive of a primary psychiatric disorder or disorder due to a GMC as accounting for the psychiatric symptoms?* The interviewer should consider such factors as a strong family history for the primary psychiatric disorder, prior episodes of these psychiatric symptoms that were unrelated to substance/medication use, and evidence for an etiological GMC.

The sections that assess the Substance/Medication-Induced Disorders end by instructing the interviewer to "return to the episode being evaluated." Recall that the SCID-5-RV evaluates Substance/Medication - Induced Disorders only in the course of evaluating one of the organic rule-out criteria—i.e., "symptoms are not attributable to the direct physiological effects of a substance (a drug of abuse, medication) or to another medical condition." Therefore, at the conclusion of this section, the interviewer must first return to the organic rule-out criterion in the disorder which was being evaluated and make the appropriate rating (i.e., a "3" if criteria are not met for both a Mental Disorder Due to Another Medical Condition AND a Substance/Medication-Induced Disorder, or a "1" if criteria are met for either). The box on the upper right-hand side of the page provides the page numbers in the SCID-5-RV to return to, depending on the disorder being evaluated.

11. SPECIAL INSTRUCTIONS FOR INDIVIDUAL MODULES

The next sections of the User's Guide provide specific instructions for each of the individual SCID-5-RV modules. It is recommended that you have a copy of the SCID to refer to while reviewing these sections.

11.1 Summary Score Sheet

The Summary Score Sheet lists the disorders included in the SCID-5 in turn, each preceded by a two-digit number used to indicate which diagnosis is "principal." The diagnostic index (in the center column of the Summary Score Sheet) indicates the extent to which the criteria for the SCID-5 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 (e.g., subject has both depressed mood and loss of interest or pleasure, but only two of the other characteristic symptoms of MDE; 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 disorders, when a rating of "3" is made, the interviewer goes on to note whether the symptom has been present "currently," a time interval that varies by disorder and can range from the past month to past 2 years, depending on what is considered to be the "current" time frame for the disorder (see Section 6.5, "Determining Whether a Diagnosis Is 'Current'," in this User's Guide).

For those diagnoses that are made only if currently present (e.g., Somatic Symptom and Related Disorders, Sleep-Wake Disorders, Adjustment Disorder), the rating in the center column instead indicates that the criteria are currently met. In cases where the diagnosis is a Disorder Due to Another Medical Condition or a Substance/Medication-Induced Disorder, there is an additional instruction (e.g., "Specify Substance: _____") indicating that the specific etiological GMC or substance/medication should be noted.

11.2 Overview

The Overview module is the foundation of the SCID and serves a number of important functions:

1) Establishing rapport between the interviewer and subject before delving into the subject's psychopathology

2) Allowing the subject to describe his or her psychopathology in his or her own words

3) Providing a contextual basis for the development of symptoms

4) Determining the subject's current functioning, which may be useful for determining the clinical significance of current symptoms

5) Exploring the subject's past functioning, which may be useful for determining the time of onset of disorders, the presence of undiagnosed psychiatric conditions, and possible comorbid medical conditions and substance use, some of which may have a role in the etiology of current or past psychopathology

6) Revealing the presence of a current or past delusional belief system in an individual who does not have insight into his or her psychosis (Sometimes the only indication of the presence of delusions is the subject's report of behavior or thinking that is unusual or atypical and does not make immediate sense to the interviewer, such as a subject with a persecutory delusion who reports that he or she has filed several lawsuits against the U.S. Postal Service for mail tampering.)

Given that the questions included in the Overview potentially cover the subject's entire life history, the challenge in doing the Overview is getting sufficient information to understand the "landscape" of the subject's life history (i.e., the rough sequence of psychiatric events) without getting caught up in details. Moreover, the interviewer should not go into detail about the subject's symptoms during the Overview because these will be extensively covered inside the individual SCID modules. The one exception is psychotic symptoms, which should be explored in detail at the point they arise during the Overview.

The Overview generally takes approximately 20–30 minutes, although interviewing subjects with particularly complex histories or who are poor historians can take considerably longer. Interviewers administering the Overview tend to make errors in either of two ways: 1) not following up on important pieces of information provided by the subject (e.g., not inquiring about the details and context of a past hospitalization for a suicide attempt); or 2) going into excessive detail about information that may be relevant for treatment planning but is not relevant to making a SCID diagnosis (e.g., obtaining the names and exact dosages of every medication that the subject has taken during his or her lifetime).

The Overview consists almost entirely of open-ended questions that mirror a general clinical interview. Thus, unlike the other sections of the SCID, in which the interviewer is expected to adhere closely to both the wording of the questions as well as their sequence, the interviewer is allowed much greater flexibility in terms of changing both the sequence and wording of the Overview questions if it makes clinical sense to do so, as long as all of the information covered in the Overview is eventually collected. For example, if at the beginning of the interview, in response to the question "With whom do you live?"

the subject explains that he just started living in a halfway house after his recent hospitalization for hallucinations that commanded him to burn down his parent's house, it would make sense to immediately inquire about the circumstances of his recent hospitalization as well as obtain more details about his recent psychotic symptoms, rather than just continuing with the next question in the Overview ("In what city, town, or neighborhood do you live?").

Two versions of the Overview are available: A **Patient Version,** which is designed to be used with individuals who are self-identified as being or having been a psychiatric patient; and a **Nonpatient Version,** which does not assume that there is a psychiatric chief complaint and is most appropriate for assessing individuals in the community or who are in treatment for a medical problem. Both versions of the Overview include sections for Demographic Data, Education and Work History, Suicidal Ideation and Behavior, Other Current Problems, and Lifetime Alcohol and Drug Use.

The Demographic Data section includes questions about age, marital status, children, and type and place of residence. This section serves mostly to establish rapport and to provide some contextual information that might be a clue to possible psychopathology (e.g., the fact that the person is living in a halfway house suggests current or past history of a relatively severe psychiatric condition). The Education and Work History section is often helpful in detecting a current or past history of psychopathology. For example, a history of interrupted schooling, multiple school failures, problematic work history, being on disability, and so forth, are all potential clues to psychopathology and demand careful follow-up to determine the reasons for these education or work problems.

The next section focuses on the presence of current psychopathology; consequently, this section differs between the two versions. The Patient Version of the Overview includes a section designed to provide an Overview of Present Illness, with subsections covering Chief Complaint and Description of Problem, Onset of Present Illness, New Symptoms or Recurrence, Environmental Context and Possible Precipitants, and Course of Present Illness or Exacerbation. This is followed by a section assessing History of Prior Mental Illness with subsections for Treatment History and Hospitalization History. 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.

When the SCID is used to interview subjects with psychotic symptoms who have limited insight into their illness, 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 who was treated with lithium in the past, may describe a possible manic episode when asked why lithium was prescribed. Of course, neither a prescribed medication nor a previous diagnosis should be used to justify making a SCID-5 diagnosis without documentation that there were symptoms that actually met criteria. 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.

In place of the sections Overview of Present Illness and History of Prior Mental Illness, the Nonpatient Version of the Overview includes a section for Current and Past Periods of Psychopathology, which inquires about any treatment that the individual may have ever had or, barring that, whether there were any periods of time in which the individual or someone else thought that he or she should seek treatment because of the way he or she was feeling or acting. Moreover, to help uncover periods of potential psychopathology that did not result in treatment seeking, the Nonpatient Version of the Overview asks the subject about when in his or her life that he or she was the most upset (immediately after the Hospitalization History section).

The next section of the Overview (both Patient and Nonpatient Versions) assesses suicidal ideation and behavior, both lifetime and in the past week. In prior editions of the SCID, suicidality was only assessed in the context of evaluating Criterion A9 in current or past MDE. Because suicidal ideation and behavior may be associated with a wide variety of disorders in addition to Major Depressive Disorder, questions have been added to the Overview to assess suicidality both for diagnostic reasons (e.g., to identify particularly severe past periods of psychopathology) and for the purpose of assessing current patient safety. The presence of current and lifetime suicidal ideation and/or behavior should be recorded by checking off the appropriate item.

The Overview then focuses on the current time period (Other Current Problems) and inquires about potential stressors, current mood, current physical health, current medications, current alcohol and drug use, and current social functioning. The Overview concludes with an assessment of lifetime alcohol and drug use. This is a change from prior editions of the SCID that assessed lifetime alcohol and drug use in the context of the Alcohol/Substance Module, which was typically done only after completing the Mood and Psychotic Modules. Because of the importance of considering the etiological role of substances and medications in the development of Mood and Psychotic Disorders, the assessment of lifetime substance use precedes the mood and psychotic sections as part of the Overview.

The procedure for conducting the substance use assessment is as follows. After introducing the assessment with the instruction "Now I'd like to ask you about your use of drugs or medicines over your lifetime," the interviewer should verbally inquire about the use of the substances in each of the listed classes, starting with the class of sedatives, hypnotics, and anxiolytics. If the subject acknowledges lifetime use of a substance in that class, the interviewer should follow up by asking questions from the box located at the bottom of the table (e.g., "Over your lifetime, when were you taking [SUBSTANCE] the most?" and so forth). The first three questions (i.e., "Over your lifetime, when were you taking [SUBSTANCE] the most?" "Have you ever had a time when your use of [SUBSTANCE] caused problems for you?" "Have you ever had a time when anyone objected to your use of [SUBSTANCE]?") aim to determine the period of heaviest or most problematic use. The last two questions (i.e., "Have you ever used [SUBSTANCE] at least six times in a 12 month period?" "Did you ever get hooked or dependent on [PRESCRIBED/OTC DRUG]?") are intended to determine whether the use of that substance was significant enough to trigger an assessment of the criteria for Substance Use Disorder later in the

interview (in Module E). Because the assessment of Substance Use Disorders has been divided into two time periods—the period of the past 12 months, and the period before the past 12 months (lifetime)—two columns are provided for rating the level of use during these time periods. The left-hand column corresponds to lifetime use, and the right-hand column corresponds to use during the past 12 months.

A rating of "3" in the left-hand lifetime column should be considered if the subject reports having used the substance more than six times in any 1 year period or becoming hooked or dependent on a prescribed or over-the-counter medication. If the subject acknowledges using the substance more than six times in the past year or else becoming dependent on a prescribed or over-the-counter medication in the past year, a rating of "3" should be given in the right-hand column.

If during the course of the assessment, the subject repeatedly denies ever using any type of illicit or recreational drug, rather than going through the complete list of substances the interviewer can choose to end the drug assessment. In such cases, however, it is suggested that the interviewer check for social response bias by normalizing drug use with the question "You mean you have never even tried marijuana?" If the subject still denies drug use, the interviewer can skip out and move on to the Screening Module.

11.3 Screening Module

The primary purpose of the Screening Module is to reduce the risk that the subject will develop a negative response bias once it becomes evident during the administration of the disorder assessments in the SCID that the interviewer responds to "YES" answers with additional follow-up, whereas a "NO" answer is "rewarded" by skipping to the next question (See Section 8.11, "Use of the Screening Module," in this User's Guide). For the same reason, "YES" answers to screening questions should not be followed by additional, improvised clarifying questions or for requests for examples. Instead, the interviewer should ask the screening questions as provided in the Screening Module without any follow-up or elaboration, with the understanding that the interviewer 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. Thus, when the subject gives a positive response to a screening question, the interviewer should respond with "We'll talk more about that later."

A definite "NO" response to a screening question should be recorded as "NO" on the Screening Module, and a definitive positive acknowledgment to the question should be recorded as "YES." Equivocal answers that would benefit from further follow-up should be left blank (i.e., not recorded as either "YES" or "NO").

Once the Screening Module is completed, the interviewer has two options regarding how to link the answers to the screening questions to the initial assessment questions within the body of the SCID. One option is to pause the interview at this point before proceeding with the assessment of Module A, and to quickly leaf through the entire SCID starting with Module F (Anxiety Disorders) in order to record all of the answers to the screening questions on the upper right-hand corner of each page that begins a new disorder, as directed in the boxes hanging under the "NO" and "YES" of the screening questions. The second option is to proceed directly with the assessment of Module A and to repeatedly refer back to the Screening Module during the SCID administration in order to check the answers to the screening questions.

Starting with Module F (Anxiety Disorders), the interviewer uses the answers to the screening questions to determine whether or not the assessment of the screened disorder can be skipped. For example, Figure 1 shows the first question in the Screening Module which screens for the lifetime presence of panic attacks. Hanging under both the "YES" and "NO" answers are boxes instructing the interviewer to circle either "YES" or "NO" in the box in the upper right-hand corner of page F.1, the initial page of the evaluation of Panic Disorder, which is shown in Figure 2. At the point in the SCID-5-RV where the interviewer begins the assessment of Panic Disorder, the interviewer asks the initial question based on whether "YES" or "NO" is circled in the upper right-hand corner of page F.1. If the answer to the screening question is "NO," the interviewer is instructed to bypass the assessment of Panic Disorder and skip to *AGORAPHOBIA,* on page F.8. If the screening question is answered "YES," the interviewer asks the first question, which is a paraphrased version of the screening question acknowledging the subject had answered "YES" to it previously, and then follows up with the provided questions, such as "When was the last bad one?" "What was it like?" and "How did it begin?" If neither the "NO" nor the "YES" is circled (i.e., the subject did not provide a clear answer to the screening question) or the interviewer decided not to use the Screening Module at all, the interviewer simply asks the initial Panic Disorder question (which is identical to the question asked in the Screening Module) and, if it is answered "YES," then asks the appropriate follow-up questions that follow immediately.

Figure 1: Example of screening question for Panic Disorder

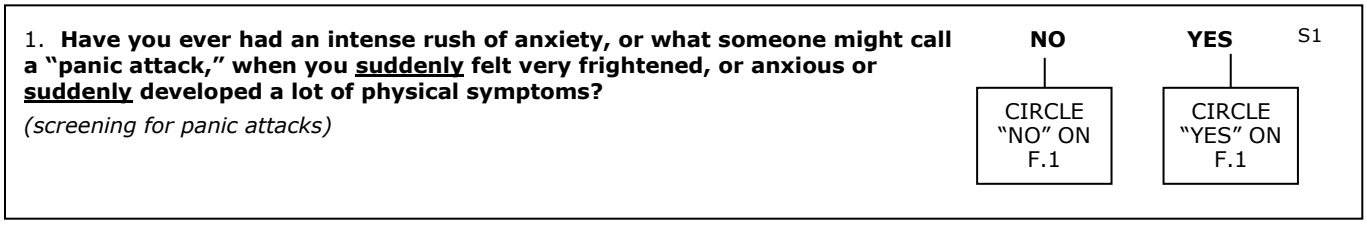
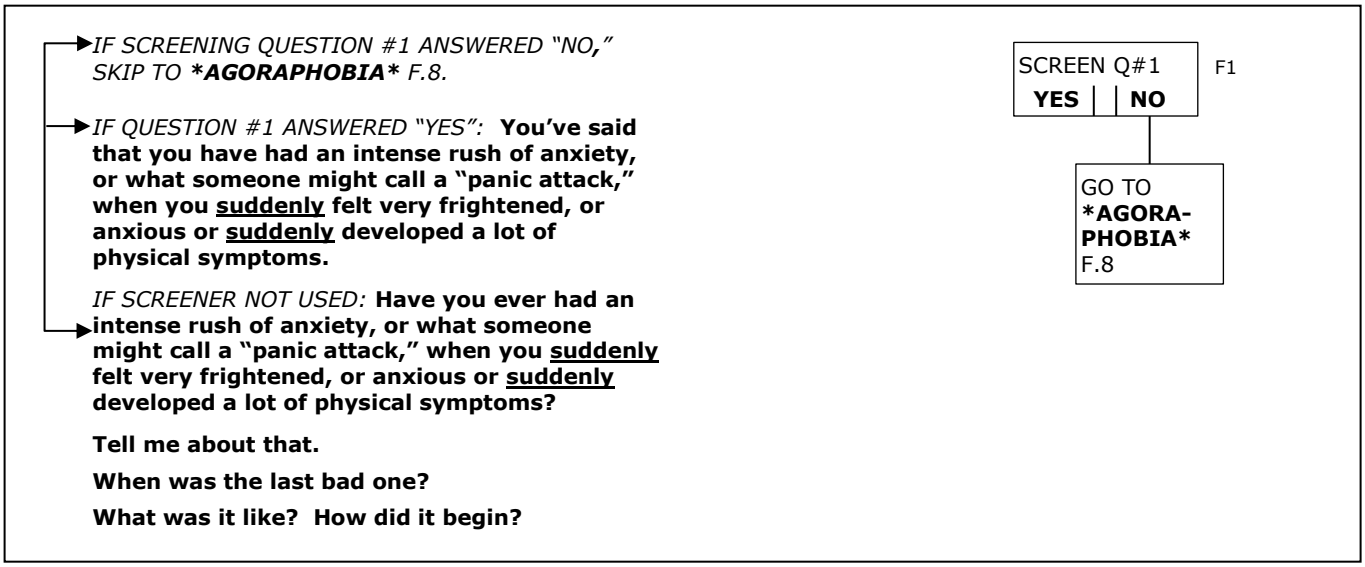


Figure 2: Corresponding questions on page F.1 of Panic Disorder



11.4 Module A. Evaluation of Mood Episodes, Cyclothymic Disorder, Persistent Depressive Disorder, and Premenstrual Dysphoric Disorder

Module A assesses current and past Major Depressive, Manic, and Hypomanic Episodes; Cyclothymic Disorder; Persistent Depressive Disorder; and Premenstrual Dysphoric Disorder (PMDD)—as well as Bipolar and Depressive Disorders Due to Another Medical Condition and Substance/Medication-Induced Bipolar and Depressive Disorders. The actual diagnoses of Bipolar I Disorder, Bipolar II Disorder, and Major Depressive Disorder are made in Module D using information collected in Module A, as well as the results of the evaluation of Psychotic Disorders in Modules B and C.

Two versions of Module A are offered in the SCID-5-RV: With Specifiers and Without Specifiers. The version with specifiers includes *all* of the mood specifiers—i.e., for current MDE: With Anxious Distress (page A.4), With Peripartum Onset (page A.4.1), With Mixed Features (pages A.4.2–A.4.3), With Catatonia (pages A.4.3–A.4.4), With Melancholic Features (pages A.4.5–A.4.6), and With Atypical Features (pages A.4.6–A.4.7); for current Manic Episode: With Anxious Distress (page A.13), With Peripartum Onset (page A.13.1), With Mixed Features (pages A.13.2–A.13.3), and With Catatonia (pages A.13.3–A.13.4); for current Hypomanic Episode: With Anxious Distress (page A.17.1), With Peripartum Onset (page A.17.2), and With Mixed Features (pages A.17.2–A.17.3); for Cyclothymic Disorder: With Anxious Distress (page A.29.1); for Persistent Depressive Disorder: With Anxious Distress (page A.32.1) and With Atypical Features (pages A.32.1–A.32.2). The other version of Module A omits all of these specifiers. Note that in order to keep the page numbers (and field codes) consistent between the two versions, the page numbers for pages containing the specifiers have a decimal point (e.g., page numbers for the current MDE specifiers range from A.4.1 to A.4.7, and are placed between pages A.4 and A.5) and the corresponding field codes are also numbered consecutively (e.g., the field codes for the current MDE specifiers go from AS1 to AS52 and are placed in between A26, the last field code for current MDE on page A.4, and A27, the first field code for past MDE on page A.5).

Current Cyclothymic Disorder, which in prior editions of the SCID could only be diagnosed as one of the types of "Other Bipolar Disorder," is now fully assessed in the SCID-5-RV, although only if current (i.e., if criteria are met for the past 2 years). The SCID-5-RV includes assessments of both current Persistent Depressive Disorder (i.e., if present for the past 2 years) and past Persistent Depressive Disorder (for prior 2 year periods of depressed mood, more days than not). Current PMDD (i.e., present for the past 12 months), which is new to DSM-5, is also included.

11.4.1 Ratings for Current Major Depressive Episode (A.1–A.4)

Criterion A—Establishing the minimum 2-week duration: When the interviewer begins to ask about a possible MDE, the first task is to determine whether there has been a 2-week period of depressed mood and/or diminished interest or pleasure that has occurred in the last month. If there is some doubt about whether the duration of the depressed mood has truly been 2 full weeks, the interviewer should inquire about the specific symptoms anyway, because often 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 2 weeks.

Establishing co-occurrence of symptoms during the same 2-week period: Once it has been determined that depressed mood or diminished interest or pleasure has persisted most of the day, nearly every day, for at least 2 weeks, the next task is to determine whether at least four additional symptoms have occurred nearly every day during the same 2-week period. This is done by first establishing with the subject a "target" 2-week period within the past month and then making sure that the subject is aware

that the next questions refer only to this 2-week period by periodically reminding the subject of the time frame when asking the questions (e.g., "during the first 2 weeks of the past month, how have you been sleeping?"). Any 2-week period in the past month can serve as the target—it is generally recommended that the interviewer focus on what the subject perceives as the worst 2 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 2 weeks. Note that if the worst period of the current episode was actually before the past month (i.e., the depressed mood has partially remitted in the past month), the interviewer should still focus on the period of the past 4 weeks to determine whether criteria are met for a current MDE. If criteria are not ultimately met, then the interviewer would continue with the assessment for a past MDE, using the worst period occurring before the past month as a focal point.

Ratings for compound items: Several of the MDE criteria contain multiple subcomponents (i.e., Criterion A3, A4, A5, A7, and A9), some of which are polar opposites (e.g., insomnia and hypersomnia, psychomotor agitation and psychomotor retardation). Even though a rating of "3" for such items reflects the presence of any one of the subcomponents (e.g., insomnia OR hypersomnia nearly every day during the 2-week period), the interviewer is instructed to indicate which of the subcomponents were present by placing a checkmark next to the listed subcomponent. *Note that this is in contrast to how such items were assessed in prior editions of the SCID, where for the sake of maximizing efficiency the interviewer was instructed to skip the questions corresponding to the latter subcomponent if there was already sufficient evidence to make a rating of "3" based on the answer to the question corresponding to the former subcomponent (e.g., for psychomotor agitation or retardation in Criterion A5, skipping the assessment of psychomotor retardation if psychomotor agitation that was noticeable to others was present and persisted for at least 2 weeks).* This was changed in the SCID-5 because many interviewers mistakenly skipped asking about the latter subcomponent when the former subcomponent was absent, and because assessing the presence of all of the subcomponents could be important both clinically and for research purposes.

COMMON ERRORS MADE IN ASSESSING MAJOR DEPRESSIVE EPISODES

One of the most common errors made in the assessment of MDE is the failure of the interviewer to ensure that each symptom has been present nearly every day during the 2-week time frame established at the beginning of the inquiry. We therefore strongly recommend that the interviewer specifically ask, "Was that true nearly every day during this period?" after each symptom, even to the point of being tediously repetitive, to ensure that this duration requirement is met for each item as required by the MDE criteria set. To underscore this point, the phrase "nearly every day" is underlined as a reminder. It should not be assumed that just because the first several symptoms are present nearly every day during the 2-week time interval, each of the rest also persisted for 2 weeks—each symptom can potentially have its own independent course (e.g., sleep and appetite changes may be present nearly every day for the 2-week period in question, but fatigue and difficulty concentrating may be present for only a minority of the days). Note that Criterion A9 (recurrent thoughts of death or suicidal ideation or a suicide attempt or specific plan) is the only criterion that 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 error is to neglect to establish a clear 2-week time frame to reference throughout Criterion A. As noted in the beginning of Criterion A, even though the initial time frame for the current MDE inquiry is "during the past month," the actual requirement is for five (or more) of the symptoms to have been present *during the same 2-week period.* Neglecting to restrict the questions to a 2-week time frame will result in the subject assuming that the minimum required duration for each item is 1 month instead of only 2 weeks. Even when the interviewer clearly states that the focus is only on a particular

2-week time interval, it is advisable to remind the subject of the applicable time frame at least once or twice during the course of assessing the nine MDE items.

A third issue that can lead to scoring errors concerns counting symptoms that occur in the context of a comorbid GMC. GMCs may manifest with the same types of symptoms that characterize a depressive episode (e.g., weight loss, insomnia, fatigue). Under what circumstances should they be attributed to the depression or the medical condition? The rule in DSM-5 is to consider such symptoms as part of the MDE UNLESS they are clearly attributable to a GMC. For example, insomnia related to frequent nocturnal coughing spells in a person with bronchitis should not count for Criterion A4.

A final issue is whether to consider, as part of the MDE, symptoms that were present before the onset of the episode (e.g., chronic insomnia). The initial part of Criterion A requires that each symptom "represent a change from previous functioning." Thus, chronic symptoms should count toward a diagnosis of an MDE 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 2 hours to fall asleep since the episode began, it would make sense to rate Criterion A4 as present for the episode.

Criterion A1—Depressed mood: Depressed mood may be acknowledged directly (e.g., "I've been feeling depressed" or "I can't stop crying"), by one of its many synonyms (sad, blue, tearful, empty, "down in the dumps"), or, in a new addition to DSM-5, as feelings of "hopelessness." Alternatively, this criterion can be rated as present if the subject reports that others have commented that he or she has seemed depressed or down. Depressed mood in an MDE can be distinguished from "ordinary" (i.e., non-pathological) depression 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 2 weeks. Note that the criterion can be rated "3" based on observational information, even if it runs counter to the subject's report (e.g., a stoic elderly patient denies being depressed, but the nursing home staff reports that the patient has been continuously tearful).

Criterion A2—Diminished interest or pleasure: Although the cardinal symptom of an MDE is depressed mood, it may be diagnosed in the absence of a subjective feeling of depression. Some patients, particularly 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 2-week interval that applies to Criteria A3–A9. Given the dual functionality of this item (i.e., as a depressive equivalent and as one of the nine symptoms that make up an MDE), two different wordings (linked by bracketed arrows) are provided for the question depending on which function applies. If the interviewer has already established the presence of depressed mood lasting at least 2 weeks (i.e., Criterion A1 is coded "3"), then the first version of the question is asked in order to determine whether there was also diminished interest or pleasure during the previously identified period of depressed mood. If, however, no 2-week period of depressed mood has been established, then the second question is asked in order to establish whether there has been a 2-week period of diminished interest or pleasure lasting most of the day, nearly every day. Evidence of this symptom may be that the subject reports a general marked diminishing of pleasure (e.g., "nothing makes me happy anymore") or provides 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 A3—Appetite/weight change: 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 2-week target period. Given that it is relatively unusual for a significant weight change to have occurred entirely within a 2-week time frame, the SCID asks about appetite changes first. The interviewer only needs to ask about weight change if there has been no significant change in appetite. Be forewarned, however, that significant changes in weight without corresponding appetite changes suggest the possibility that a GMC may be responsible for the change in weight. 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.

Criterion A4—Sleep disturbance: 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. In order to establish that the sleep pattern represents a change for the subject, it is important to establish the person's typical sleep pattern before the onset of the episode of depressed mood or diminished interest or pleasure. 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 2 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 A5—Psychomotor activity changes: 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 or unable to sit still, or he or she 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 sufficiently severe to be observed by others. Be sure to 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 motivation to do anything (rated in Criterion A2) and feelings of having no energy (rated in Criterion A6).

Criterion A6—Fatigue: Subjects with this symptom may report feeling tired all the time, "running on low power," feeling "weak" all the time, or feeling 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 (rated in Criterion A2), which may also be present.

Criterion A7—Worthlessness or guilt: Be careful in rating this item because subjects who are depressed but who do not have the full syndrome of MDE 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. While subjects often report feeling guilty about the negative impact their problems have on others (e.g., "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 that goes beyond self-reproach about being sick (e.g., "I feel like I've ruined my family forever").

Criterion A8—Cognitive disturbance: Cognitive impairment in depression is sometimes severe enough to resemble dementia. With less severe, but still significant, impairment, a subject 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 subject'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 A9—Suicidal thoughts: This is the only symptom that does not have to be present nearly every day for at least 2 weeks to warrant a rating of "3." Any recurrent active suicidal thoughts or behavior (i.e., suicidal thoughts that include a plan, intention, and means to carry out that plan) or any single suicide attempt is sufficient for a rating of "3." Having frequent thoughts of passive suicidal ideation would also warrant a "3" rating (e.g., "I'd be better off dead," "My family would be better off if I were dead"). If there are current suicidal thoughts, it is imperative that the interviewer determine the nature of the ideation (active or passive suicidal thoughts) and take appropriate action, which may include informing the clinician in charge. Self-mutilating behavior (e.g., cutting, burning) can be an expression of anger or frustration, or an attempt to control strong emotions. Self-harm behavior without suicidal intent is coded "1."

Criterion B—Clinical significance: DSM-5 has included this clinical significance criterion with 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. In most circumstances, the fact that the symptoms have had a significant impact on the subject's life will already be known to the interviewer in the course of eliciting descriptive information to support the ratings of the items making up the depressive syndrome. However, if the impact of the symptoms on the subject's functioning is unclear, additional questions are provided to help determine the impact of the symptoms on the subject's academic, occupational, and social functioning.

Criterion C—Not due to a GMC and NOT substance/medication-induced: This criterion instructs the interviewer to consider and rule out a GMC or a substance/medication as an etiological factor. See Section 10, "Differentiating General Medical and Substance/Medication Etiologies From Primary Disorders," in this User's Guide for a general discussion of how to apply this criterion, as well as how to assess the criteria for Depressive Disorder Due to Another Medical Condition and Substance/ Medication-Induced Depressive Disorder.

Number of episodes: After making a rating of "3," indicating that the criteria are met for a current MDE, the interviewer is instructed to make a rough estimate of the total number of episodes. This entails asking the subject to report how many separate times he or she has had an MDE—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. Note that according to the DSM-5 definition of "recurrent episodes" in Major Depressive Disorder, episodes are considered to be separate if there is an interval of at least 2 consecutive months in which criteria are not met for an MDE. Thus, a symptom-free period between episodes is not required.

SPECIFIERS FOR CURRENT MAJOR DEPRESSIVE EPISODE

If the interviewer is using the version of Module A that includes specifiers, the ratings for current MDE conclude with the criteria sets for the various applicable specifiers: With Anxious Distress, With Peripartum Onset, With Mixed Features, With Catatonia, With Melancholic Features, and With Atypical Features. Note that the time frame for the application of most of these specifiers differs from the time frame employed for the assessment of the qualifying symptoms of an MDE (i.e., the worst 2 weeks in

the past month). Please refer to the discussion of each of the specifiers below for the specifics. *(Note:* **Boldface** *formatting is included for some words in the specifier discussions to enhance adaptation of these specifiers with other Mood Disorders or Episodes, as later directed in this User's Guide. The boldface words are to be replaced with specific terms [e.g., "Manic Episode"] for a particular Mood Disorder or Episode.)*

WITH ANXIOUS DISTRESS: This specifier was added to DSM-5 to highlight the common clinically significant comorbidity of anxiety symptoms with episodes of **depression.** Given that the time frame for the comorbid anxiety symptoms is "the majority of days of the current **MDE**," the first question is designed to determine the onset of the current **MDE** so that the total duration of the current episode can be established. We have interpreted the phrase "during the majority of days" (a novel choice of wording that has no precedent in prior editions of the DSM) to mean that each anxiety symptom must be present for at least part of the day, for most of the days of the current **MDE**, going back to its onset. Thus, after determining that a particular anxiety symptom is present, the interviewer then asks whether it was present "for most of the days" when the subject was feeling **depressed.** At least two of the list of five symptoms (i.e., feeling keyed up or tense, feeling unusually restless, difficulty concentrating because of worry, fear that something awful may happen, fear that the individual might lose control) must be coded "3" to qualify for the specifier. The severity designation of "mild," "moderate," "moderate-severe," and "severe" should also be rated, based on the number of symptoms present and the additional assessment of whether the symptoms are accompanied by "motor agitation." (Because motor agitation is only relevant for differentiating between "moderate-severe" and "severe," the question about motor agitation is only asked if four or five of the symptoms have already been rated "3.")

Note that Criterion 5 listed in the SCID ("Feeling that the individual might lose control of [his or her anxiety or worry])" differs slightly from the wording used in DSM-5 ("Feeling that the individual might lose control of himself or herself"). During the process of developing SCID-5-RV questions for new criterion items, it was not clear how to operationalize this criterion (i.e., in what way does the individual feel that he or she may lose control of himself or herself? bladder and bowel function? impulse control? the ability to stay seated? freaking out and uncontrollably screaming?). According to the DSM-5 Mood Work Group, the items that make up the With Anxious Distress specifier criteria were based on the Generalized Anxiety Disorder criteria set. Criterion 5 in the With Anxious Distress specifier was intended to correspond to Criterion B in Generalized Anxiety Disorder ("The individual finds it difficult to control the worry"), but it was erroneously paraphrased (D. Goldberg, personal communication via e-mail, December 11, 2013). Thus, Criterion 5 included in the SCID-5-RV has been altered to indicate that the individual is specifically concerned about losing control of his or her anxiety or worry (which is enclosed in brackets to indicate the alteration).

WITH PERIPARTUM ONSET: This specifier applies if the current **MDE** had its onset at any time during pregnancy or within 4 weeks of delivery. In addition to indicating the presence or absence of this specifier, the SCID provides an additional rating to allow the interviewer to indicate whether the onset was during pregnancy or during the 4 weeks after delivery (postpartum).

WITH MIXED FEATURES: This specifier was added to DSM-5 as a replacement for the much narrower "mixed episode" construct that was previously part of the definition of Bipolar I Disorder. This specifier allows the interviewer to note the presence of subthreshold opposite-pole symptoms that are comorbid with the MDE. As was the case in the With Anxious Distress specifier, the time frame for the comorbid manic/hypomanic symptoms is "the majority of days of the current MDE." (The initial question asking about the onset of the current MDE is repeated in case the interviewer has opted to skip assessment of

the With Anxious Distress specifier for whatever reason). The bracketed ellipses indicate that the phrase "nearly every day," which was erroneously included in the DSM-5 criteria, has been omitted—instead, like With Anxious Distress, the requirement for each symptom is that it be present on most of the days when the individual was feeling depressed during the current MDE. At least three of the listed manic symptoms must be present during the majority of days for the specifier to be rated as present.

Criterion C for the With Mixed Features specifier for an MDE occurring in the context of Major Depressive Disorder (i.e., "For individuals whose symptoms meet full criteria for either mania or hypomania, the diagnosis should be bipolar I or bipolar II disorder"; DSM-5, p. 185) has been omitted from the SCID-5 for several reasons. Criterion C is simply stating that individuals with symptoms meeting criteria for a Manic or Hypomanic Episode have Bipolar I or II Disorder, and on its face this truism does not convey relevant information about the definition of the With Mixed Features specifier in the context of Major Depressive Disorder. However, given the fact that the corresponding Criterion C in the With Mixed Features specifier for an MDE in the context of Bipolar I and Bipolar II Disorder states "For individuals whose symptoms meet full episode criteria for both mania and depression simultaneously, the diagnosis should be manic episode, with mixed features"; DSM-5, p. 150), it appears that the intention of Criterion C was to set up a hierarchical relationship between a Manic Episode With Mixed Features and an MDE With Mixed Features so that Manic Episode With Mixed Features takes precedence (i.e., trumps the diagnosis of MDE With Mixed Features). Given that this hierarchical relationship between Bipolar Disorder and Major Depressive Disorder is already built into the SCID-5-RV diagnostic algorithms, its inclusion through Criterion C would likely have caused much confusion. For example, if a subject has an MDE lasting 2 weeks and every day during that episode has symptoms meeting criteria for a Manic Episode, the interviewer would diagnose a current MDE as well as the With Mixed Features specifier because of the comorbid symptoms of mania. The interviewer would then continue with the evaluation of a current Manic Episode, which would be coded as present, and then indicate the presence of With Mixed Features because of the comorbid symptoms of depression. Following the SCID-5-RV algorithm in Module D, the final diagnosis would be Bipolar I Disorder, Currently Manic, With Mixed Features.

Note also that for individuals with an MDE who have comorbid manic symptoms that meet the criteria for the With Mixed Features specifier, those manic symptoms would not automatically also meet criteria for a Manic Episode because the time frames for With Mixed Features and a Manic Episode are not identical. According to DSM-5, for the With Mixed Features specifier to apply, the symptoms are required to be present <u>for the majority of days</u> during the MDE, whereas the symptoms comprising a Manic Episode must be present <u>for most of the day, nearly every day, for at least 7 days.</u> Thus, for example, a subject might have an MDE With Mixed Features, in which the Mixed Features were present only a little more often than every other day during the MDE and thus would be considered to be present for the "majority of days of the MDE." That symptom pattern would not, however, meet criteria for a Manic Episode because of its lack of persistence.

<u>WITH CATATONIA</u>: According to DSM-5, the With Catatonia specifier applies to a current **MDE** "if catatonic features are present during most of the episode" (DSM-5, p. 186). DSM-5 then instructs the reader to "see criteria for catatonia associated with a mental disorder." These criteria, which can be found in the DSM-5 chapter "Schizophrenia Spectrum and Other Psychotic Disorders," are almost always coded based on historical information from other informants or after a review of prior records, because subjects with catatonia are unable to provide such information firsthand. Some of these items are relatively specific for catatonia and are easy to identify, like peculiar behavior and 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 2 hours getting dressed would be evidence of psychomotor retardation, whereas complete immobility for several hours would be considered catatonia. Note that in SCID-5-RV, Criterion A has been changed from what is written in DSM-5 (i.e., "The clinical picture is dominated by three [or more] of the following symptoms") to "Three or more of the following are present during most of the current **Major Depressive Episode**." This was necessary because Catatonia Associated With Another Mental Disorder requires that the catatonic symptoms dominate the clinical picture; this is at odds with the instruction for the With Catatonia specifier in **MDE**, which requires that "catatonic features are present during most of the episode." Moreover, the order of the items in the SCID-5-RV has been changed from DSM-5 so that items are grouped together based on how they are assessed: the six items assessed by observation (or by informants, including chart review) (e.g., grimacing), followed by the three items assessed during the interview (e.g., echolalia), followed by the three items assessed during physical examination (e.g., waxy flexibility).

WITH MELANCHOLIC FEATURES: The co-occurrence of melancholic symptoms during an MDE identifies a particularly severe form of depression that may be more likely to respond to biological treatment. This specifier applies to the worst period of the current episode that *may or may not* have occurred during the past month. Because some of these symptoms (e.g., Criteria A1, B4, B5, B6) are part of the nine items for MDE, the interviewer may be able to rate them without asking the subject any further questions if the worst period of the episode corresponds to the 2-week period in the past month that the interviewer inquired about during the evaluation of the current MDE. Note, however, that for this specifier, Criteria A1, B4, and B5 (i.e., "loss of interest...," "marked psychomotor retardation," and "significant anorexia," respectively) are each more severe than the corresponding items in MDE, such that additional questions may be required to ascertain that the symptom is present at the appropriate level of severity. The remaining items are specific to the With Melancholic Features specifier. The lack of reactivity in Criterion A2 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 Criterion B1, the subject must report that the depression feels qualitatively different from "normal" sadness. Some subjects report it as feeling like "being in a fog" or like being physically ill.

WITH ATYPICAL FEATURES: This specifier can be diagnosed only if the current episode does not already meet criteria for With Melancholic Features or With Catatonia. As was the case in the With Anxious Distress and With Mixed Features specifiers, the time frame for the "atypical" syndrome is "the majority of days" of the current **MDE**. (The initial question about the onset of the current **MDE** is repeated in case the interviewer has opted to skip the assessment of the With Anxious Distress and With Mixed Features specifiers for whatever reason). Unlike the prior two specifiers, which simply require the presence of anxiety or opposite-pole symptoms, these specifier criteria require that the atypical symptoms "predominate."

In contrast to With Melancholic Features, in which there is often a nonreactive mood, the specifier With Atypical Features requires that the depression be reactive (i.e., the mood brightens in response to actual or anticipated positive events). Individuals 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).

Stewart and colleagues (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- to 15-pound increase in the past 3 months, wants to

binge at least three 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 1 hour per day, 3 days per week.

11.4.2 Ratings for Past Major Depressive Episode (A.5–A.9)

If the symptoms do not meet criteria for a current episode, the interviewer then needs to inquire in detail about any past periods of depressed mood or diminished interest or pleasure. Because of the difficulty that some subjects may have in recalling both the presence and temporal relationship of specific symptoms occurring years earlier, it is essential for the interviewer to select a specific 2-week interval during the depressive period to be the target period for the subsequent eight questions. We recommend using holidays, seasons, or other life events (e.g., birthdays, graduation) as "landmarks" to narrow down the 2-week period in which the depression was the worst. To bring that time period into sharp focus in the subject's mind, another strategy is to ask specific questions about contextual factors associated with that time of the person's life (e.g., "Where were you living at the time? Where were you working? What semester or grade were you in at school?"). The process of carefully reviewing the subject's past thus serves to transform the time period from an abstraction (i.e., "that time 10 years ago when I was depressed") 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 2-week interval as follows: "I know it's hard to be this precise, but I need to focus on a 2-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." The interviewer asks: "Was it before or after spring break?" "How close was it to finals?" and so forth. We recognize that this process can be relatively time-consuming and that some interviewers may be tempted to accept a vague time frame from the subject before embarking on the past MDE assessment. We strongly recommend investing the time and energy into establishing a firm, concrete time frame because of the likely lack of validity of the subject's answers to questions such as "During that time when you were depressed 8 years ago, how was your appetite?"

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 2-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 first, even if it was not "the worst," because it is more recent and therefore the subject is more likely to have a better memory of the symptomatic details. In addition, when there are several possible episodes to choose from, it makes sense to favor episodes that occurred at times during which the subject was NOT using substances or medications that are known to cause depression and NOT suffering from a potentially etiological GMC. For example, if the subject reports two past episodes—a severe episode occurring after a period of heavy cocaine use (i.e., during withdrawal) and a milder episode occurring during an extended period of abstinence—the interviewer should start with the latter episode and consider the former episode that was comorbid with the cocaine use only if the latter episode does not meet criteria for an MDE. REMEMBER that based on the SCID-5 algorithm, ratings for past MDE need to be made ONLY IF the criteria are not met for a current MDE.

Note that when asking about a past episode, the specific wording for the introductory questions (i.e., "have you ever had…") depends on the answer to the prior introductory questions about a current period of depressed mood or diminished interest or pleasure (corresponding to Criteria A1 and A2 for current MDE, page A.1). If either of these questions was answered in the affirmative (indicating that there is a current period of depressed mood or diminished interest or pleasure that ultimately did not

meet full criteria for an MDE), then the interviewer is instructed to substitute the phrase "Has there ever been another time…" instead of "Has there ever been a time…?"

The questions covering the nine items making up Criterion A for past MDE are identical in content to their counterparts in current MDE except that they are worded in the past tense. Please refer to the instructions for Criteria A1–A9 in Section 11.4.1, "Ratings for Current Major Depressive Episode" (pp. 64–66), in this User's Guide for guidelines on evaluating these nine items. When evaluating a past MDE and the interviewer reaches a point in the evaluation when it becomes clear that the criteria are not met, if there is a history of multiple past periods of depression, it is important for the interviewer to consider whether one of the periods OTHER than the one selected may possibly meet full criteria for an MDE before skipping out of the evaluation of past MDE and continuing with the evaluation of a current Manic Episode. Even though the interviewer has presumably selected the "worst" period during the initial evaluation of past episodes, which in most cases is the one most likely to meet full criteria, there are two circumstances in which an episode other than the one selected might be more likely to meet criteria for MDE: 1) if the interviewer decided to focus on an episode in the past year (as per SCID instructions) rather than the "worst" one in the person's life; or 2) if the subject's idea of which episode was the "worst" differs from the requirements of the MDE criteria (i.e., the subject selected an episode that was the most distressing but had relatively few symptoms or a minimal impact on functioning). In any case, if there is another period of depression that is a credible candidate for meeting criteria for an MDE, the interviewer should cycle back to the beginning of the assessment of Past MDE and assess whether the MDE criteria are met for that episode.

Rating current MDE in partial remission as a past episode: Sometimes a subject is interviewed with the SCID when an MDE is partially remitted. For example, 2 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 MDE (past month) but do meet criteria for past MDE (with an onset of 2 months ago). On the score sheet, such a subject's condition is rated "3" for lifetime Major Depressive Disorder and rated "1" for "Meets Criteria Past Month." In the chronology section in Module D, "In Partial Remission" is recorded.

11.4.3 Ratings for Current Manic Episode (A.10–A.13)

Remember that for the purposes of the SCID, "current" refers to the entire past month, so the subject does not have to appear manic during the interview to be diagnosed as having a current Manic Episode.

Criterion A (Part I)—Abnormally elevated or irritable mood + increased energy or activity: Criterion A has been split into two separate parts in the SCID-5 to allow the diagnoses of both Manic Episode and Hypomanic Episode to be ruled out if the first part of the criterion is not present. The first part establishes that there has been a distinct period of abnormally elevated, expansive, or irritable mood accompanied by increased energy that has lasted for at least several days, a required feature of both a Manic Episode and a Hypomanic Episode. (The bracketed phrase "at least several days," which is not actually part of the DSM-5 criterion, has been added to provide a minimum duration of symptoms in order to justify skipping out of the assessment of a current Manic and Hypomanic Episode if this item is rated "1.") This criterion requires an abnormally and persistently elevated, expansive, or irritable mood combined with persistently increased activity or energy. Note that the requirement for persistently increased activity or energy was added in DSM-5 in order to increase the diagnostic specificity of this item.

To insure that interviewers do not neglect to inquire about irritable mood, the inquiry about irritability has been formulated into a separate question (i.e., "Have you had a period of time when you were feeling irritable, angry, or short-tempered most of the day, nearly every day, for at least several days?"). Subjects often describe either periods of irritability that are an associated feature of an MDE or chronic irritability that is a symptom of a personality disorder. Irritability that is indicative of a true Manic Episode is abnormally intense for that person (e.g., a maniacal ranting at a customer service representative versus being "snippy" with your spouse) and by definition must be accompanied by increased activity or energy, features not typically seen in an irritable depression or a personality disorder. 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 (or hypomanic) symptom questions in order to determine whether the irritability is a symptom of a Manic or Hypomanic Episode or is better accounted for by another condition like depression.

Criterion A (Part II)—1-week duration: The criteria sets for Manic Episode and Hypomanic Episode are symptomatically identical but differ in terms of minimum duration (Manic Episode has a minimum duration of 1 week, whereas Hypomanic Episode has a minimum duration of only 4 days) and severity (Manic Episodes cause significant impairment in functioning, whereas Hypomanic Episodes by definition must NOT cause significant impairment). The second half of Criterion A serves to differentiate between the two episodes on the basis of duration (i.e., if the duration of the elevated/irritable mood is less than 1 week, then the interviewer is instructed to skip to page A.16 to check for a current Hypomanic Episode). Note that an episode duration of less than 1 week could qualify for a Manic Episode if the episode is sufficiently severe to require hospitalization.

Having separate questions for the evaluation of elevated mood and irritable mood can potentially result in a diagnostic algorithm error if the following sequence of questions occurs:

1) Interviewer asks the subject about whether there has been a distinct period of abnormally elevated or euphoric mood, plus increased energy or activity.
2) Subject answers "YES," justifying a rating of "3" on the first part of Criterion A.
3) Interviewer then asks the subject about duration of elevated or euphoric mood.
4) Subject indicates that the period of elevated or euphoric mood has lasted for only 5 days (without hospitalization), so the interviewer skips to the evaluation of current Hypomanic Episode (ruling out a diagnosis of a current Manic Episode).

In this sequence, the presence of a distinct period of irritable mood is not known to the interviewer (the question about irritability was not asked, given the patient's initial positive response to the question about elevated mood). It is possible that the subject might have had a period of abnormally irritable mood plus increased activity or energy that lasted 1 week or more, justifying the continued evaluation of the criteria for a Manic Episode. Thus, a NOTE has been included in the SCID-5-RV under Part II of Criterion A instructing the interviewer to be sure to check for irritable mood lasting at least 1 week before skipping out of the evaluation of current Manic Episode (i.e., if elevated mood lasts less than 1 week, check whether irritable mood lasts at least 1 week before skipping to A.14).

It is essential to identify a 1-week time frame within the past month in order to ensure that the manic symptoms co-occur during the same 1-week period as was the case with the evaluation of a current MDE. The interviewer therefore starts the evaluation by asking the subject when, during the past month, he or she was the most manic. If the severity was relatively the same throughout the past month, then the most recent week should be used as the time frame.

Criterion B1—Inflated self-esteem or grandiosity: It is important to remember that in order to count a Criterion 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. There must be grandiosity or inflated self-esteem that is clearly not justified; merely being more self-confident than usual would not suffice for a rating of "3."

Criterion B2—Decreased need for sleep: The subject should report feeling rested after only a few hours of sleep in order to justify a rating of "3" for this item. The prototypic subject feels that he or she does not need to sleep at all and describes feeling driven or "wired" and cannot calm down enough to sleep. It is important to distinguish this item from insomnia. Both insomnia and decreased need for sleep are characterized by sleeping fewer hours than usual; however, an individual with insomnia wants to sleep, but is unable to sleep and feels tired the next day.

Criterion B3—More talkative or pressure to keep talking: 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 B4—Flight of ideas or racing thoughts: 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 the 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 B5—Distractibility: Distractibility refers to an inability to filter out extraneous stimuli (i.e., stimuli external to the person) 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. Being distracted by one's own racing thoughts would not by itself justify a rating of "3."

Criterion B6—Increased goal-directed activity or psychomotor agitation: As a consequence of elevated mood, increased energy, or increased self-esteem, the person may become involved in more goal-directed activities than usual either socially, at work or school, or sexually. Typical "manic" activities involve calling friends at all hours of the night, writing lots of letters, beginning new creative projects, or being more sexually active. Alternatively, the increase in activity may be more diffuse and be manifest as psychomotor agitation (i.e., purposeless non-goal-directed activity, such as pacing or being unable to sit still).

Criterion B7—Excessive involvement in risky activities: In the pursuit of pleasure, excitement, or thrills, or simply because of the bad judgment characteristic of mania, the person may engage in activities that are uncharacteristic of him or her, without regard to possible negative consequences. Typical examples include spending large sums of money on luxury items or services, gifts for others, or expensive vacations; reckless driving; foolish or risky business investments; or engaging in sexual indiscretions.

Criterion B—Must have three (or more) items rated "3", four if mood is only irritable: Note that the number of items required to have met Criterion B depends on whether Criterion A was rated "3" based on euphoric mood or irritable mood only. If euphoric mood has been present, then only three

Criterion B items need to have been present. Irritable mania requires a minimum of four Criterion B items to help differentiate it from irritable MDEs.

Criterion C—Causing marked impairment, requiring hospitalization, or psychotic symptoms: A comparison of the criteria for Manic Episode and Hypomanic Episode reveals that these two entities share the same symptoms but differ on minimum duration and 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 if the interviewer has reached this point in the criteria list). For this reason, if a rating of "1" is made on this item, the interviewer is instructed to skip to the criteria for current Hypomanic Episode, picking up with Criterion C, page A.16 (i.e., meeting Criteria A and B for Manic Episode necessarily means that the corresponding Criteria A and B in Hypomanic Episode are also met).

Criterion D—Not due to a GMC or substance/medication-induced: This criterion instructs the interviewer to consider and rule out a GMC or a substance/medication as an etiological factor. See Section 10, "Differentiating General Medical and Substance/Medication Etiologies From Primary Disorders," in this User's Guide for a general discussion of how to apply this criterion, as well as how to assess the criteria for Bipolar and Related Disorder Due to Another Medical Condition and Substance/Medication-Induced Bipolar and Related Disorder. Note that Manic Episodes that are triggered by somatic antidepressant treatment (including bright light therapy and electroconvulsive therapy) and that persist beyond the physiological effects of that treatment, which were considered to be substance/medication-induced under the rules of DSM-IV, are instead considered to be bona fide Manic Episodes in DSM-5. Thus, this criterion should be rated "3" for such episodes.

SPECIFIERS FOR CURRENT MANIC EPISODE

If the interviewer is using the version of Module A that includes specifiers, the ratings for current Manic Episode conclude with the criteria sets for the applicable specifiers: With Anxious Distress, With Peripartum Onset, With Mixed Features, and With Catatonia. Note that the time frame for the application of most of these specifiers differs from the time frame for the assessment of the qualifying symptoms of a Manic Episode (i.e., the worst week in the past month). Please see the discussion of each of the specifiers below.

WITH ANXIOUS DISTRESS: See p. 67 of this User's Guide for the description of the With Anxious Distress specifier in "SPECIFIERS FOR CURRENT MAJOR DEPRESSIVE EPISODE." Replace "**MDE**" with "**Manic Episode**"; "**depression**" with "**mania**"; and "**depressed**" with **manic**."

WITH PERIPARTUM ONSET: See p. 67 of this User's Guide for the description of the With Peripartum Onset specifier in "SPECIFIERS FOR CURRENT MAJOR DEPRESSIVE EPISODE." Replace "**MDE**" with "**Manic Episode**."

WITH MIXED FEATURES *(***boldface** *terms in this discussion are provided for ease of use with Section 11.4.4, "Ratings for Current Hypomanic Episode")*: This specifier was added to DSM-5 as a replacement for the much more narrowly defined "mixed episode" construct, which was part of the definition of Bipolar I Disorder, and allows the interviewer to note the presence of subthreshold opposite-pole symptoms that are comorbid with the **Manic Episode**. The time frame for the comorbid depressive symptoms is "the majority of days of the current **Manic Episode**" as was the case with the With Anxious Distress specifier. (The initial question asking about the onset of the current **Manic Episode** is repeated in case the interviewer has opted to skip assessment of the With Anxious Distress specifier for whatever

reason.) At least three of the listed depressive symptoms must have been present during the majority of days for the specifier to be rated as present.

Criterion C for the With Mixed Features specifier for a **Manic Episode** occurring in the context of Bipolar I Disorder (i.e., "For individuals whose symptoms meet full episode criteria for both mania and depression simultaneously, the diagnosis should be manic episode, with mixed features, due to the marked impairment and clinical severity of full mania"; DSM-5, p. 150) has been omitted from the SCID-5-RV because it is erroneous. Symptoms of individuals with a **Manic Episode** that simultaneously meet criteria for an MDE do not automatically meet criteria for the With Mixed Features specifier because the time frames are not identical. The With Mixed Features specifier requires that the mixed symptoms be present for the majority of days during the **Manic Episode** (and thus could be characterized by an every-other-day picture of depressive symptoms), whereas the symptoms comprising an MDE are present for most of the day, nearly every day, but for only 2 weeks. Thus, if a 2-week MDE occurs simultaneously with a much longer **Manic Episode**, the "majority of days" requirement would not be met.

WITH CATATONIA: See pp. 68–69 of this User's Guide for the description of the With Catatonia specifier in "SPECIFIERS FOR CURRENT MAJOR DEPRESSIVE EPISODE." Replace "**MDE**" or "**Major Depressive Episode**" with "**Manic Episode**."

11.4.4 Ratings for Current Hypomanic Episode (A.14–A.17)

The evaluation of Hypomanic Episode begins by checking whether the criteria have been met for a current Manic Episode and if so, skipping to the evaluation of PMDD. This has been included as a double check to ensure that the interviewer did not overlook the skip instruction at the end of the evaluation of current Manic Episode.

Criterion A—Mood disturbance + increased energy/activity lasting 4 days: The only way to reach this point in the SCID-5 is to have skipped out of the assessment of Manic Episode as part of the evaluation of Part II in Criterion A (i.e., there was a "3" rating of Part I in Criterion A for Manic Episode—indicating a period of euphoric, elevated, or irritable mood + increased energy/activity lasting for several days—and a "1" rating of Part II, indicating that the duration fell short of the 1-week minimum needed for a Manic Episode). In most cases, to evaluate this criterion the interviewer needs only to determine whether the mood disturbance + increased energy/activity lasted for at least 4 consecutive days.

Because there could have been several hypomanic episodes lasting at least 4 days in the past month, the interviewer is instructed to determine which episode was the "most extreme" and then to focus on that episode for the remaining questions in the "Current Hypomanic Episode" section.

Criterion B—Syndrome of hypomanic symptoms: By definition, a Hypomanic Episode is severe enough to be distinguishable from "normal" good mood (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. Please refer to discussion of the Criterion B items in current Manic Episode on pp. 73–74 of this User's Guide for more information.

Criterion C—Unequivocal change in functioning: To rate this criterion "3," the interviewer must ensure 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 experiencing an episode.

Criterion D—Change in functioning observable by others: To further ensure 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—Absence of marked impairment: This criterion is the opposite of Criterion C in Manic Episode; it requires that the hypomanic symptoms NOT be severe enough to cause marked functional impairment or to necessitate hospitalization and that there be no psychotic symptoms. If the symptoms are sufficiently severe to cause marked impairment, lead to hospitalization, or involve psychotic symptoms, then this item should be rated "1," ruling out a diagnosis of a current Hypomanic Episode.

In such cases, the interviewer is left with one of two options, as noted under the rating of "1" on page A.16: either consider the period of elevated or irritable mood to be a Manic Episode (i.e., hospitalization was necessary—or a reconsideration of the duration of symptoms indicates that the episode did in fact last at least 1 week, thus the original skip-out for duration less than 1 week from Part II of Criterion A for Manic Episode was not ultimately correct), or else diagnose the residual category Other Specified Bipolar Disorder later on, once the interviewer reaches Module D (Differential Diagnosis of Mood Disorders). If the interviewer chooses the former (i.e., that the episode is best considered a Manic Episode), the interviewer is instructed to return to the assessment of current Manic Episode, resuming with Criterion B on page A.10. The interviewer will also transcribe the current Hypomanic Episode Criterion B symptom ratings (from pages A.14 and A.15) to the current Manic Episode Criterion B symptom ratings (from pages A.10 and A.11), and then code "3" for Criterion C on page A.12 to indicate that the symptoms were sufficiently severe to cause marked impairment or to necessitate hospitalization or there were psychotic symptoms. 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 Other Specified Bipolar Disorder in Module D (i.e., option 4 for Other Specified Bipolar Disorder on page D.8) 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—Not due to a GMC or substance/medication-induced: This criterion instructs the interviewer to consider and rule out a GMC or a substance/medication as an etiological factor. See Section 10, "Differentiating General Medical and Substance/Medication Etiologies From Primary Disorders," in this User's Guide for a general discussion of how to apply this criterion, as well as how to assess the criteria for Bipolar and Related Disorder Due to Another Medical Condition and Substance/Medication-Induced Bipolar and Related Disorder. Note that Hypomanic Episodes that are triggered by somatic antidepressant treatment (including bright light therapy and electroconvulsive therapy) and that persist beyond the physiological effects of that treatment are NOT considered to be substance/medication-induced as they were under the rules of DSM-IV, but are instead considered to be bona fide Hypomanic Episodes under the rules of DSM-5. Thus, this criterion should be rated "3" for such episodes.

SPECIFIERS FOR CURRENT HYPOMANIC EPISODE

If the interviewer is using the version of Module A that includes specifiers, the ratings for current Hypomanic Episode conclude with the criteria sets for the various applicable specifiers: With Anxious Distress, With Peripartum Onset, and With Mixed Features. Note that the time frame for the application of most of these specifiers differs from the time frame for the assessment of the qualifying symptoms of a Hypomanic Episode (i.e., the worst 4-day period in the past month). Please see the discussion of each of the specifiers below.

WITH ANXIOUS DISTRESS: See p. 67 of this User's Guide for the description of the With Anxious Distress specifier in "SPECIFIERS FOR CURRENT MAJOR DEPRESSIVE EPISODE." Replace "**MDE**" with "**Hypomanic Episode**"; "**depression**" with "**hypomania**"; and "**depressed**" with **hypomanic**."

WITH PERIPARTUM ONSET: See p. 67 of this User's Guide for the description of the With Peripartum Onset specifier in "SPECIFIERS FOR CURRENT MAJOR DEPRESSIVE EPISODE." Replace "**MDE**" with "**Hypomanic Episode**."

WITH MIXED FEATURES: See pp. 74–75 of this User's Guide for the description of the With Mixed Features specifier in "SPECIFIERS FOR CURRENT MANIC EPISODE." Replace "**Manic Episode**" with "**Hypomanic Episode**."

11.4.5 Ratings for Past Manic and Hypomanic Episodes (A.18–A.27)

If the criteria are met for a current Manic Episode, there is no need to assess whether there are any past Manic Episodes because only one Manic Episode in the individual's lifetime is needed to establish a diagnosis of Bipolar I Disorder. However, if criteria are not met for a current Manic Episode but are met for a current Hypomanic Episode, it is still necessary to see if the criteria for a Past Manic Episode have been met in order to establish the presence of Bipolar I Disorder instead of Bipolar II Disorder.

As with the assessment of Past MDEs, when the interviewer is assessing Past Manic and/or Hypomanic Episodes, picking a specific time interval is essential (1 week for Manic Episode, 4 days for Hypomanic Episode) to serve as the target time period for the subsequent seven questions. We recommend using holidays, seasons, or other life events (e.g., birthdays, graduation) as "landmarks" to narrow down the time period in which the manic/hypomanic symptoms were the worst. Another strategy is to ask specific questions about contextual factors associated with that time of the person's life in order to bring that time period into sharp focus in the subject's mind (e.g., "Where were you living at the time? Where were you working? What semester or grade were you in at school?"). The process of carefully reviewing the subject's past thus serves to transform the time period from an abstraction (i.e., "that time 10 years ago when I was wired and on top of the world") to a more vivid memory so that the reporting of specific symptoms is more likely to be valid.

In those situations in which the subject reports more than one past manic or hypomanic period, the interviewer should establish which of the periods was the most intense, and subsequent questions should focus on the most intense 1-week period (for Manic Episode) or 4-day period (for Hypomanic 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 first, even if it was not the most intense, because it is more recent and therefore the subject is more likely to have a better memory of the symptomatic details. In addition, when there are several possible episodes to choose from, it makes sense to favor episodes that occurred at times during which the subject was NOT using substances or medications that are known to cause mania or hypomania and NOT suffering from a potentially etiological GMC. For example, if the subject reports two past episodes, a severe episode occurring during a period of heavy cocaine use and a milder episode occurring during an extended period of abstinence, the interviewer should start with the latter episode and consider the former episode that was comorbid with the cocaine use only if the latter episode does not meet criteria for a Manic or Hypomanic Episode.

Note that the specific wording for the introductory questions when asking about a past episode (i.e. "Have you ever had…") depends on the answer to the prior introductory questions about a current period of elevated or irritable mood (corresponding to the first part of Criterion A for current Manic or

Hypomanic Episode, page A.10). If either of the questions was answered "YES" (indicating that there is a current period of elevated mood or irritable mood that ultimately did not meet full criteria for a Manic or Hypomanic Episode), then the interviewer is instructed to substitute the phrase "Has there ever been another time…" instead of "Has there ever been a time…?"

The questions covering the seven items making up Criterion B for a past Manic or Hypomanic Episode are identical in content to their counterparts in current Manic or Hypomanic Episode, except that they are worded in the past tense. Please refer to pp. 73–74 of this User's Guide for guidelines on evaluating these seven Criterion B items. When evaluating a past Manic or Hypomanic Episode and the interviewer reaches a point in the evaluation when it becomes clear that the criteria are not met, if there is a history of multiple past periods of mania or hypomania, it is important for the interviewer to consider whether one of the periods OTHER than the one selected may possibly meet full criteria for a Manic or Hypomanic Episode before skipping out of this section altogether and continuing with the evaluation of current Cyclothymic Disorder. Even though the interviewer had presumably selected the most intense manic or hypomanic period (because in most cases that is the one most likely to meet full criteria), there are two circumstances in which an episode other than the one originally selected might be more likely to meet full criteria for a Manic or Hypomanic Episode: 1) If the interviewer decided to initially focus on an episode that occurred in the past year (as per SCID instructions) rather than on the "worst" one in the person's life; or 2) the subject's sense of which episode was the most intense differs from the symptomatic requirements of the Manic or Hypomanic Episode criteria (i.e., the subject selected an episode that was the most distressing but had relatively few symptoms or a minimal impact on functioning). In any case, if there is another past manic or hypomanic period that is a credible candidate for meeting criteria for a Manic or Hypomanic Episode, the interviewer should cycle back to the beginning of the assessment of Past Manic Episode or Past Hypomanic Episode and assess whether the Manic Episode or Hypomanic Episode criteria are met for that episode.

11.4.6 Ratings for Current Cyclothymic Disorder (A.28–A.29)

In previous editions of the SCID, the Cyclothymic Disorder criteria set was not assessed with interview questions but was coded as one of the "types" of "Other Bipolar Disorder" in Module D. The SCID-5 includes a formal assessment of Cyclothymic Disorder in Module A, although only current Cyclothymic Disorder (i.e., present during the past 2 years) is evaluated because most cases of Cyclothymic Disorder tend to be persistent and thus are likely to be manifest over the past 2 years. Because Cyclothymic Disorder cannot be diagnosed if criteria have ever been met for a Manic Episode, Hypomanic Episode, or MDE, the SCID-5 assessment of Cyclothymic Disorder begins with an instruction to skip to current Persistent Depressive Disorder if any mood episode has ever been present. The SCID-5 then restricts the assessment to current Cyclothymic Disorder, focusing on whether the subject has had numerous depressive periods (not meeting criteria for an MDE) and numerous hypomanic periods (not meeting criteria for a Hypomanic Episode) that have been present for at least half the time during the past 2 years. Note that Criterion D indicates that Cyclothymic Disorder is not diagnosed if the symptoms are better explained by a Psychotic Disorder. Although it may be possible to apply this criterion based on information obtained in the Overview, it may be necessary to rate this criterion provisionally and return to this point once a Psychotic Disorder has been more definitively ruled in or ruled out (Psychotic Disorders are not diagnosed until later in Module C of SCID-5).

SPECIFIERS FOR CURRENT CYCLOTHYMIC DISORDER

If the interviewer is using the version of Module A that includes specifiers, the ratings for current Cyclothymic Disorder conclude with the specifier criteria set for With Anxious Distress, which is the only specifier that applies to Cyclothymic Disorder.

WITH ANXIOUS DISTRESS: See p. 67 of this User's Guide for the description of the With Anxious Distress specifier in "SPECIFIERS FOR CURRENT MAJOR DEPRESSIVE EPISODE." Replace "**MDE**" with "**Cyclothymic Disorder**"; "**episodes of depression**" with "**hypomanic or depressive symptoms**"; and "**was feeling depressed**" with "**was having hypomanic or depressive symptoms**." Note that when this specifier is applied to Cyclothymic Disorder, the interviewer needs to consider the entire duration of the disorder, which may have persisted for years, not just the past 2 years.

11.4.7 Ratings for Current and Past Persistent Depressive Disorder (A.30–A.35)

As was done with the evaluation of mood episodes, the interviewer first assesses whether criteria are met for current Persistent Depressive Disorder (i.e., during the past 2 years). Only if criteria are not met for current Persistent Depressive Disorder does the interviewer need to assess past Persistent Depressive Disorder (pages A.33–A.35). Because the diagnosis of Persistent Depressive Disorder is not made if there has ever been a Manic or Hypomanic Episode, there is an instruction to skip to the assessment of PMDD if criteria have ever been met for a Manic or Hypomanic Episode. Criterion A (depressed mood, more days than not for 2 years); Criterion B (at least two out of six associated depressive symptoms, such as appetite changes and low self-esteem); and Criterion C (never without symptoms for more than 2 months at a time) are the same as their counterparts in DSM-IV Dysthymic Disorder. However, this DSM-5 category is not equivalent to DSM-IV Dysthymic Disorder, because in DSM-5 there is no longer any exclusion for concurrent MDEs. In DSM-5, Persistent Depressive Disorder applies to any chronic depressive picture lasting at least 2 years; thus, any combination of mild depressive symptoms and MDEs is covered by this diagnostic entity.

Three such configurations (which can be indicated using the course specifiers) are specifically included in SCID-5-RV: 1) a "pure" dysthymic presentation, in which there is depressed mood for more days than not and that is never severe enough to meet criteria for a full MDE; 2) an MDE that has lasted continuously for 2 years (which would have been specified as "chronic" in DSM-IV); and 3) a mixture of baseline dysthymic symptoms and superimposed MDEs (sometimes referred to as "double depression"). The fact that a continuous MDE lasting at least 2 years can qualify for this diagnosis is indicated by Criterion D ("Criteria for a major depressive disorder may be continuously present for 2 years"; DSM-5, p. 168). However, because this statement does not actually function as a true diagnostic criterion (it is neither an essential feature for the diagnosis of Persistent Depressive Disorder nor is it an exclusion criterion) and thus cannot be meaningfully rated in the SCID, it has been omitted. Instead, the presence of a continuous current MDE is indicated using the applicable specifier (With Persistent Major Depressive Episode) on page A.32.

Note that Criterion F indicates that Persistent Depressive Disorder is not diagnosed if the symptoms are better explained by a Psychotic Disorder. Although it may be possible to apply this criterion based on information obtained in the Overview, it may be necessary to rate this criterion provisionally and return to this point once a Psychotic Disorder has been more definitively ruled in or ruled out (Psychotic Disorders are not diagnosed until later in Module C of SCID-5).

The evaluation of current Persistent Depressive Disorder concludes with the assessment of three specifiers. The first specifier, either Early Onset or Late Onset, indicates whether the Persistent Depressive Disorder has an early onset (i.e., before age 21) or late onset (i.e., age 21 or older). The second specifier indicates the pattern of symptoms over the past 2 years (With Pure Dysthymic Syndrome; With Persistent Major Depressive Episode; With Intermittent Major Depressive Episodes, With Current Episode; With Intermittent Major Depressive Episodes, Without Current Episode). The

evaluation of this specifier may require the interviewer to ask additional questions, taking into account the possible presence of a current MDE as well as possible past MDEs that were determined earlier in the module. The final specifier indicates the presence of comorbid panic attacks. Usually this specifier is recorded only after evaluating the presence of panic attacks and Panic Disorder on pages F.1–F.6. This specifier is used if there are panic attacks in the past month that occur in the context of Persistent Depressive Disorder and only if criteria have never been met for Panic Disorder.

SPECIFIERS FOR CURRENT PERSISTENT DEPRESSIVE DISORDER
If the interviewer is using the version of Module A that includes specifiers, the ratings for current Persistent Depressive Disorder conclude with an evaluation of the criteria for the With Anxious Distress and With Atypical Features specifiers that serve to describe certain symptomatic profiles of the entire period of the Persistent Depressive Disorder. Although the DSM-5 criteria set lists a number of other specifiers that appear to apply to the Persistent Depressive Disorder diagnosis, such as With Mixed Features and With Melancholic Features (DSM-5, p. 169), these specifiers apply only to the symptomatic profile of a current MDE that may have been comorbid with the Persistent Depressive Disorder and do not describe the symptomatic profile of Persistent Depressive Disorder itself. Because these episode-related specifiers will already have been evaluated in the context of a current MDE, they do not need to be evaluated a second time.

WITH ANXIOUS DISTRESS: See p. 67 of this User's Guide for the description of the With Anxious Distress specifier in "SPECIFIERS FOR CURRENT MAJOR DEPRESSIVE EPISODE." Replace "**MDE**" with "**period of Persistent Depressive Disorder.**" Note that when this specifier is applied to Persistent Depressive Disorder, the interviewer needs to consider the entire duration of the disorder, which may have persisted for years, and not just the past 2 years.

WITH ATYPICAL FEATURES: See pp. 69–70 of this User's Guide for the description of the With Atypical Features specifier in "SPECIFIERS FOR CURRENT MAJOR DEPRESSIVE EPISODE." Replace "**MDE**" with "**period of Persistent Depressive Disorder.**" Note that when this specifier is applied to Persistent Depressive Disorder, the interviewer needs to consider the entire duration of the disorder, which may have persisted for years, and not just the past 2 years.

11.4.8 Ratings for Current Premenstrual Dysphoric Disorder (A.36–A.40)

PMDD is a severe form of premenstrual syndrome (PMS). Like PMS, PMDD follows a predictable, cyclic pattern. Symptoms begin in the late luteal phase of the menstrual cycle (after ovulation) and remit around the onset of menses. The symptoms last 6 days on average, with the most intense symptoms occurring in the 2 days before the day of the start of menstrual blood flow. In PMDD, mood symptoms are dominant and substantial disruption to personal relationships is typical. The symptoms occur during the week before menstruation, and must remit by the end of the first week of menstruation. Because PMDD can occur only in menstruating females between the time of menarche and menopause, the interviewer is instructed to skip to the next module if the subject is a biological male, a pregnant female, a postmenopausal female, or a female who has undergone a hysterectomy and oophorectomy.

Criterion A—Temporal pattern and number of mood symptoms: The evaluation of this item centers on establishing the required temporal pattern of the mood symptoms—that is, they have their onset during the late luteal phase of the menstrual cycle (i.e., are present in the final week premenses) and remit completely during menses for the majority of cycles over the past 12 months. Even though Criterion A does not explicitly state a required duration of the symptom-free period, a question has been added (based on recommendations from the DSM-5 Mood Work Group) to determine whether the symptoms

remitted for a least 1 week, in order to operationalize the requirement that symptoms remit postmenses. Similarly, the note advising the interviewer to recheck symptom-free and symptom-present intervals if the number of days per month is 20 or greater has been added as a red flag for symptom patterns that are not consistent with the typical PMDD presentation.

Criterion B—Mood disturbance: At least one severe mood symptom (i.e., marked affective lability; marked irritability or anger or increased interpersonal conflicts; marked depressed mood, feelings of hopelessness, or self-deprecating thoughts; or marked anxiety, tension, and/or feelings of being keyed up or on edge) must be present during the late luteal phase symptomatic periods. This requirement has been operationalized in the SCID-5-RV by having the interviewer ask the subject to think of the single most severe premenstrual episode during the past 12 months when answering the questions about the specific mood symptoms. Each mood symptom question is accompanied by a follow-up question ("Did this go away when your menstrual period began or shortly after?") to highlight the importance of establishing that the symptoms remit postmenses.

Criterion C—Other symptoms: This criterion establishes that one or more additional characteristic mental or physical symptoms must also be present and that the total number of symptoms (combining those in Criterion B and Criterion C) must be at least five. As with the symptom inquiry in Criterion B, each symptom question in Criterion C is accompanied by a follow-up question to establish remission of each symptom postmenses in order for it to count.

Criteria A–C—Symptoms present for most cycles in past year: Even though Criterion A begins with the phrase "in the majority of menstrual cycles," DSM-5 (and the SCID-5-RV) includes a rating corresponding to the note after Criterion C that states, "The symptoms in Criteria A–C must have been met for most menstrual cycles that occurred in the preceding year." As indicated in the SCID-5-RV, this has been operationalized so that a rating of "3" requires the symptoms to have been present for at least six cycles in the past year.

Criterion D—Clinical significance: One of the key features that differentiate PMDD from PMS is the required impact on functioning. DSM-5 has included this clinical significance criterion with most of the disorders in order to emphasize the requirement that a symptom pattern must lead to "clinically significant" impairment or distress before being considered diagnosable as a mental disorder. In most cases, the fact that the symptoms have had a significant impact on the subject's life will already be known to the interviewer after eliciting descriptive information to support the ratings of the symptoms making up the disorder. However, if the impact of the symptoms on the subject's functioning is unclear, additional questions are provided to help determine the impact of the symptoms on the subject's academic, occupational, and social functioning.

Criterion E—Not an exacerbation of an existing disorder: The prior questions confirm that the mood symptoms completely remit postmenses, and thus usually rule out the possibility that the symptoms are an exacerbation of an existing Mood Disorder. However, the SCID-5-RV includes an additional question assessing this issue because of its explicit inclusion in Criterion E.

Criterion G—Not due to a GMC or substance/medication-induced: This criterion instructs the interviewer to consider and rule out a GMC or a substance/medication as an etiological factor. See Section 10, "Differentiating General Medical and Substance/Medication Etiologies From Primary Disorders," in this User's Guide for a general discussion of how to apply this criterion, as well as how to assess the criteria for Depressive Disorder Due to Another Medical Condition and Substance/Medication-Induced Depressive Disorder.

Criterion F—Confirmed by daily ratings: This criterion has been placed at the end of the assessment of PMDD; it determines whether the diagnosis is "definitive" or "provisional." This requirement was added because of evidence that women tend to overattribute mood symptoms to the premenstrual period of their cycle when asked to retrospectively report the temporal nature of their mood symptoms. DSM-5 therefore requires prospective daily ratings for at least two cycles for a definitive diagnosis. Given that many (if not most) subjects will not have completed two cycles of prospective ratings before the SCID-5-RV interview, if all other PMDD criteria have been met, the subjects are given a provisional diagnosis of PMDD rather than a definitive diagnosis.

11.4.9 Ratings for Bipolar Disorder Due to Another Medical Condition, Substance/Medication-Induced Bipolar Disorder, Depressive Disorder Due to Another Medical Condition, and Substance/Medication-Induced Depressive Disorder (A.41–A.50)

These final sections of Module A are consulted only in the course of evaluating the organic rule-out criterion that is included in the criteria sets for MDE, Manic Episode, Hypomanic Episode, Cyclothymic Disorder, Persistent Depressive Disorder, and PMDD in Module A, and for Other Specified Bipolar Disorder and Other Specified Depressive Disorder in Module D. The SCID-5 rule is that if there is any indication that a drug of abuse, medication, or another 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. See Section 10, "Differentiating General Medical and Substance/Medication Etiologies From Primary Disorders," in this User's Guide for a general discussion of how to assess the criteria for these disorders.

11.5 Module B. Psychotic and Associated Symptoms

Module B is for assessing the lifetime occurrence of psychotic symptoms (e.g., delusions, hallucinations). Ratings for the specific criteria are contained in Module C (i.e., ratings for Schizophrenia; Schizophreniform, Schizoaffective, and Brief Psychotic Disorders; Psychotic Disorder Due to Another Medical Condition; and Substance/Medication-Induced Psychotic Disorder) and Module D (i.e., ratings for Bipolar I Disorder With Psychotic Features and Major Depressive Disorder With Psychotic Features).

This module serves as both a checklist for recording psychotic symptoms that have emerged during the course of the SCID-5-RV interview as well as a screener for the various types of psychotic symptoms that define the DSM-5 Psychotic Disorders. Because the interviewer is assessing lifetime psychotic symptoms, it is necessary to date the occurrences of specific symptoms. For most subjects with a Psychotic Disorder, the presence of a psychotic symptom has usually been established prior to Module B (typically in the Overview). 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 these instances, Module B may serve more as a checklist for recording those psychotic symptoms than as 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 necessarily apply. Summarizing the subject's psychotic phenomenon in the form of the paraphrased screening question may be excessively off-putting to the subject and might negatively impact rapport, so if the interviewer is certain that a particular psychotic symptom is present, it may be permissible to rate the symptom as present without re-asking the question. For example, if during the Overview the interviewer has already established that the subject believes that he is God, there is no need to confirm the presence of a grandiose delusion by saying to the subject, "You've told me that you are especially important in some way or that you have special powers or knowledge." However, given that different delusions of the same type may have been present over the subject's lifetime, the question should instead be paraphrased to inquire about that possibility (e.g., "Have you ever thought that you were especially important in some other way, or that you had other special powers or knowledge?").

When used as a screener, each of the Module B questions should be asked verbatim except if the answer is already known (see above), as per the standard SCID convention. For each question answered "YES," the first step is to determine whether or not it represents a delusional belief. Thus, it is essential to ask multiple follow-up questions that are designed to elicit, in an open-ended way, the details of the individual's belief in order to determine whether or not it is evidence of a psychotic symptom. In order to reduce the risk of false negatives, many of these questions are written quite broadly with the understanding that they are likely to elicit positive responses in those who are not psychotic. For example, the question for persecutory delusions asks the subject "What about anyone going out of their way to give you a hard time, or trying to hurt you?" Many individuals who have had an acquaintance, coworker, or supervisor who is mean or vindictive will answer "YES" to this question. The interviewer therefore needs to ask additional detailed questions to elicit sufficient information to allow for a differentiation between a realistic scenario that is not likely evidence of a delusion—and a scenario that strains credulity (e.g., the belief that one's entire coterie of coworkers has been meeting off-hours at a secret location to plan ways to harass the individual) and suggests the presence of a persecutory delusion. As a general rule, the subject should be given the benefit of the doubt when trying to determine whether or not a particular incident is evidence of psychosis; a "3" should be coded only when the interviewer is satisfied that the scenario is evidence of psychosis.

For each item coded "3," the interviewer should record a description of the symptom (e.g., "is convinced the CIA has implanted a listening device into his ear"), its frequency (e.g., "daily, several times a day"), and its impact on the subject's life ("e.g., "generally able to ignore this belief").

It is essential to ask all subjects, especially those who have already reported psychotic symptoms, all of the psychosis screening questions. These questions are useful both as a general screener for psychotic symptoms and as a way to determine the full range, lifetime duration, and course of psychotic symptoms in individuals with a psychotic disorder. The same principle applies to the ratings for those psychotic symptoms that have multiple questions corresponding to the rating. So, for example, even though the delusions of reference item includes five questions covering various types of referential experiences, it is important to ask about each one so that the full duration and impact on the subject's life of delusions of reference can be determined.

Module B begins with a choice of introductory statements, separated by a bracket. If the subject has already acknowledged that he or she has had psychotic symptoms in the past, the interviewer should start with the first choice ("You've told me about (PSYCHOTIC SXS). Now I'd like to ask you about other experiences like that.") If the subject has not reported any psychotic symptoms so far during the interview, the interviewer should start with the second choice ("Now I'd like to ask you about unusual experiences that people sometimes have").

11.5.1 Ratings of Delusions (B.1–B.4)

A *delusion* is a fixed 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 an individual 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 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 incorrectly drawn from observation of the person's environment or self (e.g., believing that occasional phone hang-ups prove that the individual is the subject of an FBI surveillance operation). 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 someone dialing a wrong number?). A subject with delusions may acknowledge the possibility of these explanations, but will still hold firm to his or her own belief.

Some subjects with a long-standing history of psychotic disorder have developed insight into the "psychotic" nature of their delusions. Such delusions would still be considered "psychotic" as long as, at some earlier point, they were experienced by the subject 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 long-standing

Schizophrenia. This would be coded as a delusion if the subject either 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).

TYPES OF DELUSIONS

The first set of ratings inquires about the lifetime occurrence of the various types of delusions, on the basis of theme and content. Note that more than one rating may apply for a particular delusion if the content of the delusion covers several themes. 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." The SCID-5 has added a number of additional questions for delusions and has provided separate definitions and ratings for religious delusions, delusions of guilt, jealous delusions, and erotomanic delusions, all of which were previously rated under "other delusions."

DELUSION OF REFERENCE: There is a relatively high false positive response rate to the initial question for this type of delusion ("Has it ever seemed like people were talking about you or taking special notice of you?") because it asks about a relatively common experience. The interviewer should therefore ask for specific examples that establish the psychotic nature of the belief. Most people have at some time 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." Because delusions of reference can be manifested in a variety of situations, a number of additional questions are provided covering a range of stimuli that are often misinterpreted as having personal significance, such as believing that something on a TV program, the radio, or in a movie; the words to a popular song; the clothes that people are wearing; or what is written on signs or billboards are intended to send the person a special message.

PERSECUTORY DELUSION: As noted earlier, 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. The two follow-up questions ("Have you ever had the feeling that you were being followed, spied on, manipulated, or plotted against?" and "Did you ever have the feeling that you were being poisoned or that your food had been tampered with?") can be helpful in identifying the more obvious cases. There may be cases in which it is particularly challenging to determine whether the persecution is real or delusional. These cases should be coded "?" until more information is obtained and a final decision can be made.

GRANDIOSE DELUSION: It is sometimes hard to tell where a subject's inflated perception of his or her talents ends and a grandiose delusion begins. A taxi driver who believes he will write a best-selling novel may be mistaken but is not necessarily delusional. If, however, he tells the interviewer that Steven Spielberg has been calling and 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 (e.g., 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 subject with physical symptoms who doubts an internist's reassurance that she has no medical illness. If the subject is able to entertain the possibility that her beliefs are exaggerated, then the diagnosis would be Somatic Symptom Disorder or Illness Anxiety Disorder (optional disorders assessed in Module J). A subject who dismisses such reassurances out of hand is more likely to have a somatic delusion. Note that a subject's delusional belief that a part of his or her body is ugly or defective is no longer recorded as a somatic delusion but instead is considered to be evidence for Body Dysmorphic Disorder, With Absent Insight.

DELUSION OF GUILT: This type of delusion involves a subject's belief that a minor error in the past will lead to disaster, that he or she has committed a horrible crime and should be punished severely, or that he or she is responsible for a disaster (e.g., an earthquake or fire) for which there can be no possible connection. Consequently, three questions have been included covering having committed a crime, having done something that would result in harm to others, and being responsible for a disaster. Because it is certainly possible for a subject to have been responsible for hurting others, the interviewer must obtain sufficient details to establish the credibility of the subject's belief that he or she was responsible.

JEALOUS DELUSION: The essential feature of this delusion is that the subject's sexual partner is unfaithful. For example, when asked about jealous delusions, a subject may respond that his wife is having an affair with the next-door neighbor. The interviewer's task is to determine the plausibility of these claims (e.g., what did the subject see or hear to give him that impression, has anyone else observed the partner being unfaithful). Again, distinguishing a jealous delusion from concerns justified by the partner's behavior can be challenging. Usually the judgment that a belief is evidence of psychosis depends on details of the person's belief stretching the bounds of believability (e.g., the subject's belief that her husband is having sex with a mistress during the 3 minutes in which he is outside taking out the trash).

RELIGIOUS DELUSION: This item should be coded "3" if the delusion involves religious or spiritual content. Distinguishing a religious delusion from a religious belief can be particularly challenging. One of the elements of the DSM-5 glossary definition of delusion (reprinted verbatim in the SCID-5) is that the belief be *false*; this standard cannot be applied to religious beliefs because they cannot be proven to be either true or false. Instead, the method suggested in DSM-5 for deciding whether a religious belief is likely to be delusional is to determine whether or not the belief is ordinarily accepted by other members of that person's religious community as a part of the canon of beliefs.

Given the importance of the subject's spiritual worldview, the first question is intended to determine whether the subject considers himself or herself to be a religious or spiritual person. If so, the follow-up question asks whether the subject has ever had any religious or spiritual experiences that others in his or her religious circle have not experienced. If so, then the subject is asked to describe those experiences, as well as the reactions of other members of his or her religious community to those beliefs. If the subject has not shared these beliefs with others, then it will be up to the interviewer to make the determination about whether these beliefs significantly deviate from the "norm" dictated by that subject's religious circle. If the interviewer is not familiar enough with the subject's religion to be able to make such a judgment, it may be necessary for the interviewer to speak with others who are members of the subject's religion or to consult with other outside sources in order to determine whether the subject's belief falls within the norm. If the subject denies having beliefs that are not shared by others in his or her community, then the interviewer asks whether the subject has ever directly communicated with "God, the devil, or some other spiritual being or higher power." Because such

communication is an experience common to a number of religions, it is essential for the interviewer to determine whether such direct communication deviates from the religious norm. For those individuals who report such beliefs but who have never been religious or spiritual before having those beliefs, the details of how these beliefs arose may be more indicative of a delusional process.

EROTOMANIC DELUSION: With this type of delusion, the subject is convinced that another person, usually of higher status, is in love with him or her. For example, when asked about erotomanic delusions, a subject may respond that she "knows" that a specific celebrity is secretly in love with her—but when she tried to make contact, the celebrity denied even knowing her. In some cases, the subject will simply assert that he has been romantically involved with someone famous or powerful. Of course, because this could feasibly be true, it is essential to elicit as many details as possible about the relationship in order to assess whether it is fantasy or reality.

DELUSION OF BEING CONTROLLED: With this type of delusion, the subject experiences his or her feelings, impulses, thoughts, or actions as being under the direct control of some external force rather than under his or her own control. Because individuals with such delusions usually report this as something they are experiencing rather than as a belief, the SCID-5 question is framed in terms of ever having had such a feeling. However, this item is coded "3" (i.e., it represents a delusion) *only* if the individual is convinced that this experience is real. It is important to avoid confusing the colloquial experience of being in a controlling relationship as evidence of this delusion. 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 to determine whether the subject 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 INSERTION/THOUGHT WITHDRAWAL: Along the same lines as delusions of control, some individuals with Schizophrenia may have the experience of their thoughts being controlled by some sort of outside influence. Specifically, this might entail feeling that thoughts have been inserted into their mind or that thoughts have been removed from their brain. These items are coded "3" (i.e., they represent delusions) *only* if the person is convinced that these experiences are real.

THOUGHT BROADCASTING: This delusion involves the subject's feeling that his or her thoughts are being broadcast out loud so that they can be perceived by others. This item is coded "3" *only* if the subject is convinced that these experiences are real. It may be helpful to ask the subject for an explanation of how this may be happening, as a delusional interpretation of the experience (e.g., "a thought transmitter has been surgically implanted in my head") usually justifies a rating of "3." However, a recounting of the mechanism is not necessarily required for a rating of "3," as long as the subject reports these experiences as being real. If the subject experiences the broadcast thoughts as a hallucination (i.e., the subject can hear his thoughts as well), the item for auditory hallucinations should also be rated "3." Note that thought broadcasting is not the same as the more commonly reported experience that others can read one's mind, which would be recorded under the next item, "Other Delusions."

OTHER DELUSIONS: This item is for rating delusions that have content not covered by any of the above types, such as the subject's belief that others can read his or her mind; a nihilistic delusion (i.e., that everything, including the self, does not exist); or the related delusion that he or she has already died.

BIZARRE DELUSION: This item is for rating whether any of the delusions previously recorded qualify as "bizarre." In prior editions of the SCID, this rating was diagnostically significant, because if there were bizarre delusions or certain kinds of auditory hallucinations, the DSM-IV Schizophrenia criteria allowed an exception to the Criterion A requirement that two out of five active phase symptoms be present. This provision was eliminated in DSM-5. The rating indicating that delusions are bizarre has been retained in the SCID-5 to facilitate rating of the "with bizarre content" specifier in Delusional Disorder.

When making this rating, it is important to differentiate between a delusion that is truly "bizarre" (i.e., involving a phenomenon that the subject's culture would regard as totally implausible), and one that is simply unlikely. An example of a nonbizarre delusion is the subject's belief that he is being followed by the FBI. On the other hand, the subject's belief that the FBI has implanted a computer chip in his brain and is controlling all of his actions would be considered bizarre.

Rating severity of delusions in the past week: This dimensional rating (from 0 to 4) is taken from the Clinician-Rated Dimensions of Psychosis Symptom Severity scale in DSM-5 (pp. 742–744). The rating should be based on the maximum severity of any delusion that may have been present in the past week. A rating of "0" should be given if there have not been any delusions or delusion-like experiences (including overvalued ideas) present in the past week. A rating of "1" (equivocal) should be given if there is evidence of a delusion-like experience in the past week that is below the minimum threshold necessary to be considered a delusion—i.e., it would have merited a rating of "2" (rather than "3") on one of the delusion ratings, because either the belief was not held with delusional intensity or it was too fleeting to be considered clinically significant. The interviewer gives a dimensional severity rating of a "2" (mild); "3" (moderate); or "4" (severe) if there have been any delusions present in the past 7 days at the minimum severity level to be considered a delusion. The decision as to whether to make a rating of mild, moderate, or severe requires consideration of the following:

1) The impact of the delusion on the subject's life in terms of the degree to which he or she is inclined to act on the delusion (i.e., mild = little pressure to act; moderate = some pressure to act; severe = severe pressure to act);
2) The degree to which the subject is preoccupied with his or her delusional beliefs (i.e., mild = not very preoccupied; moderate = somewhat preoccupied; severe = completely preoccupied); or
3) The degree to which the subject is "bothered" by the delusional beliefs (i.e., mild = not very bothered by beliefs; moderate = somewhat bothered; severe = very bothered).

Interview questions have been provided for each of these factors (i.e., "Did you do anything because of [DELUSIONS]?" "How often have you been thinking about [DELUSIONS]?" and "How bothered have you been by [DELUSIONS]?"). All three of these factors should be considered and the overall severity rating should reflect the one that is the most severe at its most severe point in the past 7 days. Note that the issue of the degree of preoccupation with the delusions does not appear in the original DSM-5 version of this scale but was added after consultation with the DSM-5 Schizophrenia Work Group, in the context of discussions regarding operationalization of this scale. SCID-5 users who wish to remain faithful to the original scale should not count the degree of preoccupation toward the rating of severity.

11.5.2 Ratings of Hallucinations (B.4–B.5)

A *hallucination* is the experience of sensory perception without stimulation of the relevant sensory organ. A hallucination should be distinguished from an illusion, which is the misperception of an actual stimulus (e.g., misinterpreting a shadow as the figure of a man).

TYPES OF HALLUCINATIONS

AUDITORY HALLUCINATIONS: Auditory hallucinations should be differentiated from delusions of reference, in which the subject hears actual voices (e.g., on the street, on the ward) and interprets them self-referentially. Evidence that the voices 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.

VISUAL, TACTILE, SOMATIC, GUSTATORY, AND OLFACTORY HALLUCINATIONS: Visual hallucinations must be particularly distinguished from illusions, which are misperceptions of real stimuli (e.g., mistaking a pile of clothes in a dimly lit room for an animal). Visual phenomena during the transition to and from wakefulness and sleep (hypnagogic and hypnopompic hallucinations) should be coded "1." Tactile hallucinations involve sensations that are perceived through the surface of the skin (e.g., being stroked, the feeling of crawling insects). Somatic hallucinations involve sensations perceived to be inside the body (e.g., a feeling of electricity). Gustatory hallucinations, which involve the sense of taste, and olfactory hallucinations, which involve the sense of smell, can be challenging to differentiate from the individual having a particularly acute sense of taste or smell, given that the questions are framed in terms of tasting or smelling things that no one else can taste or smell. The details of the experience (e.g., persistence in multiple situations) and the nature of the smell or taste (e.g., rotting flesh, gasoline) might be especially suggestive of a hallucinatory experience.

Rating severity of hallucinations in the past week: This dimensional rating (from 0 to 4) is taken from the Clinician-Rated Dimensions of Psychosis Symptom Severity scale in DSM-5 (pp. 742–744). The rating should be based on the maximum severity of any hallucination in any sensory modality that may have been present in the past week. A rating of "0" should be given if there have not been any unusual perceptual experiences in the past week. A rating of "1" (equivocal) should be given if there is evidence of a perceptual experience in the past week that is below the minimum threshold necessary to be considered a hallucination—i.e., it would have merited a rating of "2" (rather than "3") on one of the hallucination ratings, because the experience was so transient as to be without clinical significance. The interviewer gives a dimensional severity rating of "2" (mild); "3" (moderate); or "4" (severe) if there have been any hallucinations present in the past 7 days at the minimum severity level to be considered a hallucination. The decision as to whether to make a rating of mild, moderate, or severe entails a consideration of the impact of the hallucination on the subject's life in terms of the following:

1) The degree to which the subject is inclined to act on the voices or other hallucinations, such as by talking back to voices or obeying a command hallucinations (i.e., mild = little pressure to act or respond; moderate = some pressure to act or respond; severe = severe pressure to act or respond); or
2) The degree to which the subject is "bothered" by the voices or other hallucinations (i.e., mild = not very bothered by voices or other hallucinations; moderate = somewhat bothered; severe = very bothered).

Interview questions have been provided for each of these factors (i.e., "Did you do anything because of (HALLUCINATIONS)?" "Did you talk to (HALLUCINATION)?" "If the voices told you to do something, did you do it?" and "In the past week, how much did (HALLUCINATION) bother you?"). All of these factors should be considered and the overall severity rating should reflect the most severe hallucination at its most severe point in the past 7 days.

11.5.3 Ratings for Disorganized Speech and Behavior and Catatonia (B.6–B.8)

DISORGANIZED SPEECH: While current disorganized speech can be assessed during the course of the SCID interview, past instances must be determined by history and almost always require an informant. If the subject's current 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 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.

Rating severity of disorganized speech in the past week: This dimensional rating (from 0 to 4) is taken from the Clinician-Rated Dimensions of Psychosis Symptom Severity scale in DSM-5 (pp. 742–744). Given that this rating is based on the maximum severity of the subject's disorganized speech over the past week, information from other informants about the subject's speech during the past week will likely be needed. A rating of "0" should be given if there has not been any evidence at all of disorganized speech in the past week. A rating of "1" (equivocal) should be given if there is evidence of some disorganized speech in the past week that is below the minimum threshold necessary to be considered sufficient to count toward a diagnosis of Schizophrenia (i.e., it is not severe enough to substantially impair effective communication). The interviewer gives a dimensional severity rating of "2" (mild); "3" (moderate); or "4" (severe) if the subject's disorganized speech is at least at threshold (i.e., it impairs effective communication) based on the interviewer's judgment of how difficult it is to follow the subject's speech (mild = some difficulty; moderate = speech often difficult to follow; severe = speech is impossible to follow).

GROSSLY 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.

CATATONIC BEHAVIOR: These items come from the criteria set for Catatonia Associated with Another Mental Disorder in DSM-5 (pp. 119–120). The DSM-5 Catatonia criteria set defines the With Catatonia specifier for Manic Episode, MDE, Schizophrenia, Schizophreniform Disorder, Schizoaffective Disorder, and Brief Psychotic Disorder; and it requires a minimum of *three* items in order to establish the presence of a "catatonia syndrome." However, in SCID-5 Module B, no minimum symptom requirement is set forth (i.e., only *one* symptom is potentially required to meet Criterion A4 for Schizophrenia and Schizophreniform Disorder). The Catatonia items are almost always rated based on historical information from informants or after a review of prior records, because subjects with catatonia are typically unable to provide such information firsthand. Note that the order of the Module B Catatonia items has been changed from the DSM-5 Catatonia criteria set so that items are grouped together based on how they are assessed: the six items assessed by observation or through informants, including chart

review (e.g., grimacing); followed by the three items assessed during the interview (e.g., echolalia); followed by the three items assessed during physical examination (e.g., waxy flexibility).

Rating severity of abnormal psychomotor behavior in the past week: This dimensional rating (from 0 to 4) is taken from the Clinician-Rated Dimensions of Psychosis Symptom Severity scale in DSM-5 (pp. 742–744). Given that this rating is based on the maximum severity of the subject's disorganized and/or catatonic behavior over the past week, information from other informants about the subject's behavior during the past week will likely be needed. A rating of "0" should be given if there has not been any evidence at all of disorganized or catatonic behavior in the past week. A rating of "1" (equivocal) should be given if there is evidence of some disorganized or catatonic behavior in the past week that is not severe enough to be considered clinically significant, and therefore is below the minimum threshold necessary to count toward the diagnosis of Schizophrenia. The interviewer gives a dimensional severity rating of "2" (mild); "3" (moderate); or "4" (severe) if the subject's disorganized or catatonic behavior is at least at threshold (i.e., it is clinically significant) based on the interviewer's judgment of how frequent the behavior has been (mild = occasional abnormal or bizarre motor behavior; moderate = frequent; severe = almost constant).

11.5.4 Ratings of Negative Symptoms (B.8–B.9)

NEGATIVE SYMPTOMS: The main challenge regarding the diagnosis of negative symptoms is the risk of 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 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 at things. Furthermore, it is important to ensure 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 mimic negative symptoms. For example, many individuals taking 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 before the onset of the neuroleptic treatment, and a reduction or change in medication or the addition of an anticholinergic agent can sometimes be informative. It can also be difficult to distinguish between negative symptoms (diminished emotional expressiveness 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 who is unable to maintain a job because of persecutory delusions would not necessarily 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 GMC and substance/medication as the cause of psychopathology.

Rating severity of negative symptoms in the past week: This dimensional rating (from 0 to 4) is taken from the Clinician-Rated Dimensions of Psychosis Symptom Severity scale in DSM-5 (pp. 742–744). To assist in this determination, the SCID includes several questions that assess the possible presence of negative symptoms (e.g., "Tell me how you spend your time. What are your goals?" and so forth). Given that this rating is based on the maximum severity of the subject's behavior and thinking over the past week and not just how the subject presents to the interviewer during the SCID interview, information from other informants about the subject's behavior during the entire past week may be needed to supplement the information obtained during the interview. A rating of "0" should be given if there has not been any evidence at all of a decrease in facial reciprocity, prosody, gestures, or self-initiated behavior during the past week. A rating of "1" (equivocal) should be given if there is equivocal evidence of a decrease in facial reciprocity, prosody, gestures, or self-initiated behavior during the past week that is not enough to be considered clinically significant. The interviewer gives a dimensional severity rating of "2" (mild); "3" (moderate); or "4" (severe) if the subject's decrease in facial reciprocity, prosody, gestures, or self-initiated behavior is at least at threshold (i.e., it is clinically significant) based on the interviewer's judgment of its severity, ranging from mild to severe. Given that no guidelines or examples of mild, moderate, or severe are provided in DSM-5, the interviewer will have to exercise his or her own clinical judgment, based on the impact of these symptoms on functioning and how persistent they have been during the past week.

11.5.5 Chronology of Psychotic Symptoms (B.10)

Module B concludes with a summary of the specifics of the course for those psychotic symptoms that have been coded "3." For each symptom (listed on a separate line), the interviewer should note the type of symptom (e.g., persecutory delusion of being followed by the FBI), course (e.g., intermittent), onset (e.g., June 2009), offset (e.g., September 2009), and whether or not the symptom has been present in the past month.

11.6 Module B/C. Psychotic Screening

The Psychotic Screening Module B/C can be used as an alternative to the more detailed (and separate) Modules B and C in the SCID-5-RV. Its purpose is to determine whether a delusion or hallucination has been present at any time in the subject's lifetime and whether or not it is primary or due to a substance/medication or GMC. There is no evidence that negative answers to any subset of questions about delusions and hallucinations can validly rule out a lifetime history of psychosis, so it was not possible to reduce the number of questions about delusions and hallucinations in the Psychotic Screening Module B/C as compared to the standard Module B. However, in contrast to the standard Module B and Module C, Module B/C does not include ratings for other psychotic symptoms (e.g., disorganized speech) and does not include the diagnostic algorithm that allows the interviewer to determine which DSM-5 Psychotic Disorder best accounts for the psychotic symptoms. Module B/C is intended for use in studies in which cases with primary psychotic symptoms are to be excluded (i.e., psychotic symptoms that are not due to a substance/medication or GMC and that occur outside the context of a Mood Disorder).

In Module B/C, each psychotic symptom that is present is essentially rated twice. The first rating indicates the presence (or absence) of the psychotic symptom. If the symptom is present (i.e., coded "3"), the interviewer must make a second rating, indicating whether the symptom is possibly or definitely due to a substance/medication or due to the direct physiological consequences of a GMC (rating of "1") or is primary (i.e., not due to a substance/medication or a GMC). The box on page B/C.1 contains interview questions that might be useful for this purpose (e.g., "Just before (PSYCHOTIC SXS) began, were you using drugs?").

The Psychotic Screening Module B/C concludes with two ratings summarizing the results of the screening process. The first rating indicates whether any primary psychotic symptoms have ever been present in the subject's lifetime (i.e., coded "3" for the item and then coded "3" again to indicate that it is "primary"). The second rating indicates whether any primary psychotic symptoms occur at times other than during mood episodes. This may be useful for studies that exclude subjects who have ever had a primary nonmood psychotic disorder.

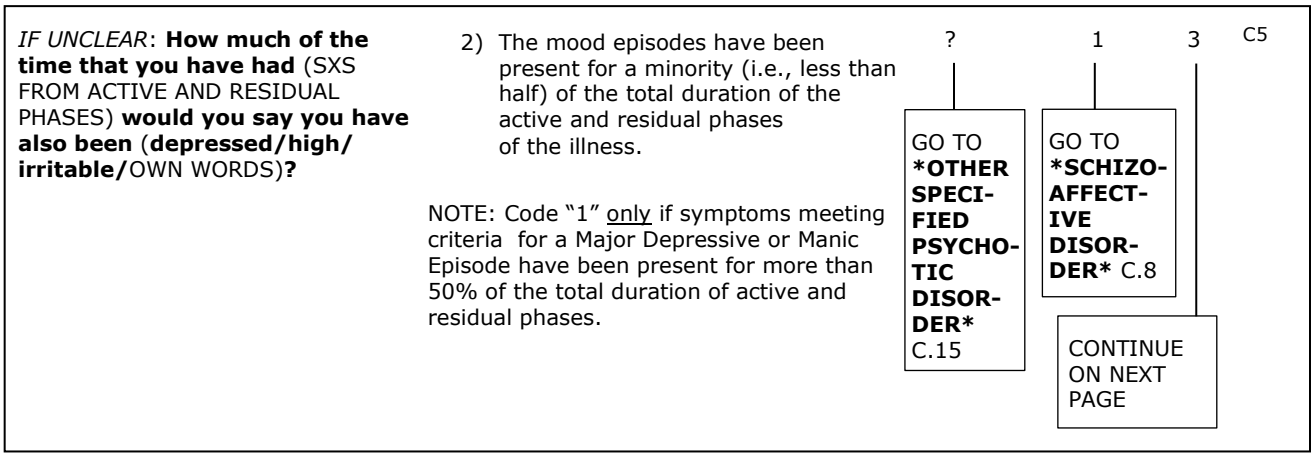
11.7 Module C. Differential Diagnosis of Psychotic Disorders

This module helps the interviewer to make a differential diagnosis of Psychotic Disorders based on information obtained in Modules A and B. Module C is skipped if the subject has never had a psychotic symptom. Module C contains assessments for the following conditions:

Schizophrenia
Schizophreniform Disorder
Schizoaffective Disorder
Delusional Disorder
Brief Psychotic Disorder
Psychotic Disorder Due to Another Medical Condition
Substance/Medication-Induced Psychotic Disorder
Other Specified Psychotic Disorder

Structurally, Module C differs from Modules A and B in several ways. The goal in Module C is to determine which Psychotic Disorder best accounts for the symptoms rated in Modules A and B, whereas the primary goal in Modules A and B is to collect specific information from the subject (and/or informants) about the clinical presentation in order to determine whether individual criteria for Psychotic Disorders are met. Thus, the main focus in the assessment of disorders in Module C is on whether the diagnostic criterion in the center column is present or absent based on ratings of items in Modules A and B. Consequently, ratings for the criterion items in Module C are confined to "?," "1," and "3"—for most items, a rating of "2" (subthreshold) is not available given that each criterion is either present or absent. Because many of the items have multiple clauses and involve double negatives, notes written in all capital letters are provided below many of the criterion items as a quick guide to making the ratings. For example, Figure 3 shows the note listed below Schizophrenia Criterion D2. It is suggested that the interviewer review these notes before making the final rating to confirm that the criterion item has been interpreted correctly.

Figure 3: SCID interview question and clarifying note for Schizophrenia Criterion D2



For most of the items in Module C, there is no need to ask a question, although for some items additional questions may be required for clarification, especially for those criteria requiring a judgment about the temporal relationships of symptoms. For example, as shown in Figure 3 above, although it is

possible that the interviewer might have sufficient information about the lifetime duration of mood episodes and psychotic symptoms in Modules A and B to rate this item, in most cases it is advantageous to ask the subject this question in order to verify the temporal relationships between the mood and psychotic symptoms.

Under typical circumstances, the latter half of Module B and most of Module C is assessed without needing to ask the subject any additional questions. Thus, from the subject's perspective, the last thing heard aloud until the beginning of Alcohol Use Disorders in Module E is the interviewer saying, "Let us stop for a moment while I make a few notes" on page B.6 (followed by the interviewer flipping through pages and making item ratings while the subject patiently looks on). In order to minimize subject waiting time, it is advisable for the interviewer to become proficient with this section so it can be done quickly and efficiently. We strongly recommend that novice SCID users practice going through Module C using the case vignettes in Appendix C of the User's Guide. We caution against the practice of skipping Module C during the SCID interview with the idea that it can be completed later when the subject is no longer present, because additional questions of the subject may be required in order to rate certain criteria.

Note that there are two situations in which the interviewer may have to return to Module A after completing Modules B and C to recode items:

1) If the diagnosis of Persistent Depressive Disorder was made in Module A and then a Psychotic Disorder diagnosis is made in Module C, the rating for Criterion F in Persistent Depressive Disorder (i.e., "does not occur exclusively during a chronic psychotic disorder") may have to be recoded; OR
2) Because of the difficulty distinguishing the negative symptoms of Schizophrenia from symptoms of depression, an MDE that has been previously diagnosed in Module A might need to be recoded if a diagnosis of Schizophrenia is later made in Module C. In these cases, the interviewer should return to Module A and recode any equivocal items as "1" if they are better explained as negative symptoms of Schizophrenia.

Some psychotic disorders tend to be chronic (e.g., Schizophrenia, Delusional Disorder) whereas others tend to be more episodic (e.g., 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 changes markedly 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) whereas another temporally disconnected episode meets the criteria for Schizophreniform Disorder (delusions and hallucinations persisting for 4 months without any mood symptoms). In such instances, we recommend that each episode be given its own diagnosis as a way of communicating the most information—an admittedly suboptimal solution, as such individuals probably do NOT have more than one disorder.

11.7.1 R/O Psychotic Mood Disorder (C.1)

The hallmark of the diagnoses of Bipolar Disorder With Psychotic Features and Major Depressive Disorder With Psychotic Features is that the psychotic symptoms occur only during mood episodes. Thus, the initial step in the differential diagnosis of mood and psychotic symptoms is to skip out of Module C (Differential Diagnosis of Psychotic Disorders) and continue with Module D (Differential Diagnosis of Mood Disorders) if all the psychotic symptoms are confined to episodes of mood disorder. This initial criterion is not actually part of the criteria set for any DSM-5 disorder but has been included

in the SCID-5 to allow the interviewer to skip past the evaluation of nonmood psychotic disorder in such cases.

11.7.2 Ratings for Schizophrenia (C.1–C.5)

The criteria for Schizophrenia are presented in the SCID-5 in a different order than in DSM-5 to maximize diagnostic efficiency. For example, the interviewer immediately skips out of Schizophrenia if the temporal relationship between mood and psychotic symptoms (Criterion D) indicates Schizoaffective Disorder or a Depressive or Bipolar Disorder With Psychotic Features. Similarly, Criterion C (duration of at least 6 months) precedes Criterion B (decline in functioning) to allow the interviewer to immediately skip out of the assessment of Schizophrenia and continue with Schizophreniform Disorder if the duration is less than 6 months.

Criterion A—Two or more symptoms during a 1-month period: 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. Criterion A requires that two out of the five listed symptoms must have been present for a significant portion of time during a 1-month period (or "less if successfully treated"), one of which must have been delusions, hallucinations, or disorganized speech. The interviewer will need to refer to the ratings of the corresponding psychotic symptoms in Module B in order to score this criterion and must determine both a minimum duration (i.e., was it a significant portion of time during a 1-month period?) and whether at least two symptoms have clustered during the same period of time. Note that the inclusion of the phrase "or less if successfully treated" acknowledges that clinical judgment is required when applying the duration criterion. For a subject who has been promptly and aggressively treated with antipsychotic medication, if the other aspects of the illness are unequivocally present, the 1-month duration requirement is waived.

Criterion D—Rule-out of other disorders and determination of symptom duration: 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 Depressive or Bipolar Disorder With Psychotic Features. As discussed above (in Section 11.7.1, "R/O Psychotic Mood Disorder"), the interviewer has already been instructed to skip out of Module C if the psychotic symptoms are confined to MDEs and Manic Episodes (indicating that the diagnosis is Depressive or Bipolar Disorder With Psychotic Features), leaving the differential diagnosis to Schizophrenia or Schizoaffective Disorder. Criterion D delineates the admittedly inexact boundary between Schizophrenia and Schizoaffective Disorder—a rating of "3" on this item indicates that Schizoaffective Disorder has been ruled out, with the interviewer being instructed to continue with Schizophrenia Criterion C on page C.4. A rating of "1" on Criterion D indicates that the diagnosis is more likely to be Schizoaffective Disorder and that the interview should resume on page C.8.

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 an MDE or Manic 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 episodes and the total duration of the psychotic disturbance. If the total duration of the mood episodes is less than 50% (i.e., a minority) of the total duration of the psychotic 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 total duration of the mood episodes adds up to more than 50% of the total duration of the psychotic disturbance, then Criterion D is rated "1," and the interviewer proceeds with the criteria for Schizoaffective Disorder on page C.8.

Note that this criterion is one of the few in the SCID in which the "?" rating has its own skip instruction to page C.15 (directing the interviewer to make a diagnosis of Other Specified Psychotic Disorder). 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 Other Specified Psychotic Disorder (and Other Specified Depressive Disorder or Other Specified Bipolar Disorder in Module D) is probably the most appropriate choice.

Criterion C—Disturbance persists for at least 6 months: The 6-month duration criterion, which differentiates Schizophrenia from Schizophreniform Disorder, is generally only an issue in subjects who are having their first psychotic break. Note that the 6-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 Schizophrenia Criterion A5). Alternatively, the subject can be considered to be in the prodromal or residual phase if there are milder versions of the symptoms listed in Schizophrenia Criteria A1–A4. For example, 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; but they have not yet developed frank delusions or they are recovering from a phase of having frank delusions. Similarly, a subject who experiences hallucinations during the active phase may have unusual perceptual experiences in the prodromal or residual phase (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 phase. The person may continue to act in a peculiar fashion but no longer exhibit grossly disorganized behavior.

Note that the listing of prodromal/residual symptoms on page C.3 of the SCID-5-RV has been adapted from DSM-5 text (p. 101) and the DSM-III-R list of prodromal/residual symptoms (pp. 194–195), which was the last DSM edition to explicitly list prodromal/residual symptoms.

Criterion B—Markedly impaired level of functioning: This includes such things as interpersonal relations, self-care, academic achievement, and occupational functioning. Functional impairment resulting from the above symptoms is usually quite evident from the Overview, so this is a question that the interviewer will usually not need to ask.

Criterion E—Not due to a GMC and not substance/medication-induced: This criterion instructs the interviewer to consider and rule out a GMC or a substance/medication as an etiological factor. See Section 10, "Differentiating General Medical and Substance/Medication Etiologies From Primary Disorders," in this User's Guide for a general discussion of how to apply this criterion, as well as how to assess the criteria for Psychotic Disorder Due to Another Medical Condition and Substance/Medication-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 GMC or substance/medication etiology.

If the subject has had a primary psychotic disorder but also has psychotic symptoms that are due to a GMC or to a substance/medication, both the primary psychotic disorder and the Psychotic Disorder Due to Another Medical Condition and/or Substance/Medication-Induced Psychotic Disorder 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 (i.e., go through Module C again after making the diagnosis of Psychotic Disorder Due to Another Medical Condition or Substance/Medication-Induced Psychotic Disorder) only if the subject has also had psychotic symptoms at other times (i.e., when not using substances/medications and/or when not suffering from a GMC).

Criterion F—If history of Autism Spectrum Disorder or Communication Disorder: Because of the resemblance of symptoms of Autism Spectrum Disorder and Social Communication Disorder to residual phase symptoms of Schizophrenia, a diagnosis of Schizophrenia can only be made in such individuals if there have also been delusions or hallucinations present at some point in the individual's lifetime that have persisted for a significant portion of a 1-month period of time.

SPECIFIERS FOR SCHIZOPHRENIA

WITH CATATONIA: This specifier applies if the DSM-5 criteria (pp. 119–120) for the catatonia syndrome are met, which requires that the current clinical picture be dominated by at least three catatonic symptoms that were rated "3" on pages B.7–B.8. Because these symptoms were rated for a lifetime period, it might be necessary to recheck to see if they are present during the current episode of illness.

An additional course specifier is rated in the Schizophrenia/Delusional Disorder/Schizoaffective Disorder chronology section, which starts on page C.17.

11.7.3 Ratings for Schizophreniform Disorder (C.6–C.7)

The SCID resumes at this point if Criteria A and D of Schizophrenia are present (i.e., active phase symptoms for at least 1 month, and Schizoaffective Disorder has been ruled out), but Criterion C is not true (i.e., total symptom duration is NOT greater than 6 months).

Criterion A—Psychotic symptoms: This criterion has already been assessed for Schizophrenia.

Criterion B—Duration of 1+ months: It is important to ensure that the psychotic symptoms have lasted at least 1 month, because it is possible to have arrived at this point in the SCID with the subject having had a period of psychotic symptoms with a duration of less than 1 month (e.g., delusions and hallucinations that remitted after 2 weeks due to successful treatment with neuroleptics). For psychotic symptoms lasting less than 1 month, the SCID skips to the assessment of Brief Psychotic Disorder on page C.13.

Criterion C—Schizoaffective Disorder and Mood Disorder With Psychotic Features have been ruled out: This criterion has already been assessed for Schizophrenia.

Criterion D—Not due to a GMC and not substance/medication-induced: This criterion instructs the interviewer to consider and rule out a GMC or a substance/medication as an etiological factor. See Section 10, "Differentiating General Medical and Substance/Medication Etiologies From Primary

Disorders," in this User's Guide for a general discussion of how to apply this criterion, as well as how to assess the criteria for Psychotic Disorder Due to Another Medical Condition and Substance/Medication-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 GMC or substance/medication etiology.

If the subject has had a primary psychotic disorder but also has psychotic symptoms that are due to a GMC or to a substance/medication, both the primary psychotic disorder and the Psychotic Disorder Due to Another Medical Condition and/or Substance/Medication-Induced Psychotic Disorder 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 (i.e., go through Module C again after making the diagnosis of Psychotic Disorder Due to Another Medical Condition or Substance/Medication-Induced Psychotic Disorder) only if the subject has also had psychotic symptoms at other times (i.e., when not using substances/medications and/or when not suffering from a GMC).

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 4 months ago), "provisional" may be indicated by a rating of "2."

SPECIFIERS FOR SCHIZOPHRENIFORM DISORDER
WITH AND WITHOUT GOOD PROGNOSTIC FEATURES: This specifier requires the presence of at least two of the following features: onset of prominent psychotic symptoms within 4 weeks of the first noticeable change in unusual behavior or functioning; confusion or perplexity; good premorbid social and occupational functioning; and absence of blunted or flat affect.

WITH CATATONIA: This specifier applies if the DSM-5 criteria (pp. 119–120) for the catatonia syndrome are met, which require that the current clinical picture be dominated by at least three catatonic symptoms that were rated "3" on SCID-5 pages B.7–B.8. Because these symptoms were rated for lifetime, it might be necessary to recheck to see if they are present during the current episode of illness.

11.7.4 Ratings for Schizoaffective Disorder (C.8–C.9)

The SCID interview picks up at this point if Criterion A for Schizophrenia is rated "3" (i.e., active phase symptoms for at least 1 month) and both Criterion D1 and D2 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 more than 50% of the total duration of the disturbance).

Criterion A—Major mood episode concurrent with Schizophrenia Criterion A: This criterion requires that there be an MDE or Manic Episode concurrent with a period of time during which there were two or more active phase symptoms of Schizophrenia, each symptom present for a significant portion of time during a 1-month period.

It can be a clinical challenge to sort out the degree to which a particular symptom is attributable to a mood episode, Criterion A of Schizophrenia, a medication side effect, or some combination of the three. For example, depressive symptoms can be difficult to distinguish from negative symptoms or antipsychotic medication side effects, and it can be difficult to determine whether disorganized, excited behavior is part of Criterion A of Schizophrenia or characteristic of a Manic Episode. For this reason, MDEs 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—Delusions or hallucinations for 2+ weeks: This criterion ensures that the delusions or hallucinations have lasted for at least 2 weeks in the absence of an MDE or Manic Episode. Criterion B theoretically serves to distinguish Schizoaffective Disorder from Mood Disorder With Psychotic Features, because in prototypical Bipolar or Major Depressive Disorder With Psychotic Features, the psychotic symptoms are completely confined to the mood disorder episodes. However, given that the first item in Module C already asked whether all of the subject's psychotic symptoms were confined to MDEs or Manic Episodes, a "1" rating for this item indicates that any psychotic symptoms that have occurred outside of the mood episodes have lasted less than 2 weeks, thus ruling out both Mood Disorder With Psychotic Features and Schizoaffective Disorder. Such cases (i.e., those rated "?" or "1") are diagnosed as Other Specified Psychotic Disorder.

Criterion C—Total duration of mood episodes compared with duration of disturbance: This item is the inverse of Criterion D2 for Schizophrenia (in which the mood episodes are required to have been present for a minority—i.e., less than half—of the total duration of the active and residual phases of the illness). Criterion C for Schizoaffective Disorder thus requires that the total duration of mood episodes be more than 50% of the total duration of the disturbance. Theoretically, it should not be possible to code anything other than a "3," because the interviewer would not ordinarily be at this point in the SCID unless Criterion D2 in Schizophrenia was coded "1." If for some reason this was not the case, then the diagnosis would be Other Specified Psychotic Disorder.

Criterion D—Not due to a GMC and not substance/medication-induced: This criterion instructs the interviewer to consider and rule out a GMC or a substance/medication as an etiological factor. See Section 10, "Differentiating General Medical and Substance/Medication Etiologies From Primary Disorders," in this User's Guide for a general discussion of how to apply this criterion, as well as how to assess the criteria for Psychotic Disorder Due to Another Medical Condition and Substance/Medication-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/medication etiology.

If the subject has had a primary psychotic disorder but also has psychotic symptoms that are due to a GMC or to a substance/medication, both the primary psychotic disorder and the Psychotic Disorder Due to Another Medical Condition and/or Substance/Medication-Induced Psychotic Disorder 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 (i.e., go through Module C again after making the diagnosis of Psychotic Disorder Due to Another Medical Condition or Substance/Medication-Induced Psychotic Disorder) if there is evidence that the subject has also had psychotic symptoms at other times (i.e., when not using substances/medications and/or when not suffering from a GMC).

An additional course specifier is rated in the Schizophrenia/Delusional Disorder/Schizoaffective Disorder chronology section, which starts on page C.17.

SPECIFIERS FOR SCHIZOAFFECTIVE DISORDER

BIPOLAR TYPE/DEPRESSIVE TYPE: This specifier reflects the lifetime pattern of mood episodes—if there has ever been a Manic Episode during the course of the illness, Bipolar Type applies; otherwise it is Depressive Type.

WITH CATATONIA: This specifier applies if the DSM-5 criteria (pp. 119–120) for the catatonia syndrome are met, which require that the current clinical picture be dominated by at least three catatonic symptoms that were rated "3" on SCID-5 pages B.7–B.8. Because these symptoms were rated for lifetime, it might be necessary to recheck to see if they are present during the current episode of illness.

11.7.5 Ratings for Delusional Disorder (C.10–C.12)

The SCID interview resumes at this point if Criterion A for Schizophrenia is not met (i.e., two or more of the five active phase symptoms have never been present during the same 1-month period), thus ruling out Schizophrenia, Schizophreniform Disorder, and Schizoaffective Disorder. If Schizophrenia Criterion A was not met for reasons other than the presence of delusions without other psychotic symptoms (e.g., the presence of significant hallucinations), then the interviewer is instructed to skip out of the assessment of Delusional Disorder and proceed with the assessment of Brief Psychotic Disorder. Moreover, in keeping with the DSM-5 addition of the specifier With Absent Insight/Delusional Beliefs in Body Dysmorphic Disorder and OCD, the interviewer is instructed to skip out of the assessment of Delusional Disorder if the subject's distorted beliefs are restricted to beliefs about appearance or the feared consequences of not performing a compulsion. The interviewer should consider applying the specifier With Absent Insight/Delusional Beliefs in Body Dysmorphic Disorder (optional) or OCD in Module G.

As was the case with Schizophrenia (Section 11.7.2, "Ratings for Schizophrenia"), Criterion D is presented first for efficiency; it rules out a Major Depressive or Bipolar Disorder With Psychotic Features.

Criterion D—Brief total duration of mood episodes relative to delusional disturbance: Analogous to Criterion D in Schizophrenia, this criterion guides the differential diagnosis for individuals with mood episodes and long-standing delusions. If the subject has had mood episodes that have been relatively brief compared to the total duration of the delusions, then the diagnosis is consistent with Delusional Disorder and the interviewer is instructed to code "3" and continue with the evaluation of the remaining Delusional Disorder criteria. For example, persistent and prominent delusions for many years with only occasional and relatively brief mood episodes would be diagnosed as Delusional Disorder. If the mood episodes are not brief compared to the duration of the delusions, the differential diagnosis is between either Mood Disorder With Psychotic Features if the delusions occur only during mood episodes or Other Specified Psychotic Disorder for presentations in which the mood episodes are not brief, yet there are periods of time when the subject is delusional in the absence of significant mood symptoms. (Schizoaffective Disorder is not in the differential because Schizoaffective Disorder requires that the psychotic symptoms meet Criterion A of Schizophrenia, which would require psychotic symptoms in addition to the delusions.) Given that Module C began by having the interviewer evaluate whether the psychotic symptoms occurred only during mood episodes (in which case the interviewer was instructed to skip directly to Module D), the only presentations that would be left are the latter (i.e., delusions with mood episodes that were not brief), and thus a rating of "1" for this item results in a skip to Other Specified Psychotic Disorder.

Criteria A and B—Delusions for 1+ months: Delusional Disorder requires at least 1 month of delusions that occur generally in the absence of other psychotic symptoms. However, according to Criterion B, some accompanying psychotic symptoms may be present, as 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 subject having the perception of emitting a foul body odor related to the delusion that neighbors are avoiding him).

Criterion C—No other symptoms or impairment: 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—Not due to a GMC and not substance/medication-induced or another mental disorder: The first half of this criterion instructs the interviewer to consider and rule out a GMC or a substance/ medication as an etiological factor. See Section 10, "Differentiating General Medical and Substance/ Medication Etiologies From Primary Disorders," in this User's Guide for a general discussion of how to apply this criterion, as well as how to assess the criteria for Psychotic Disorder Due to Another Medical Condition and Substance/Medication-Induced Psychotic Disorder.

The second half of Criterion E reminds the interviewer *not* to make the diagnosis if the symptoms are better explained by another mental disorder. Delusional forms of OCD and Body Dysmorphic Disorder have already been excluded through the skip instruction that appears at the beginning of the assessment of Delusional Disorder. Note that delusional forms of Illness Anxiety Disorder (e.g., the subject being convinced that he or she is dying of a brain tumor despite the absence of supportive medical evidence) are included in Delusional Disorder and thus are not excluded (i.e., there is no With Absent Insight specifier associated with this disorder).

SUBTYPES AND SPECIFIERS FOR DELUSIONAL DISORDER

THEMATIC SUBTYPES: A number of mutually exclusive subtypes (e.g., Persecutory, Jealous, Erotomanic, Somatic, Grandiose) are provided to allow the interviewer to indicate the predominant theme of the delusion, corresponding to the different types of delusions rated in Module B. If no one type of delusion predominates, the Mixed Type is indicated. If the theme is not covered by those listed, the Unspecified Type is assigned.

WITH BIZARRE CONTENT: This specifier is used if the content of the delusion has been rated as "bizarre" on the bottom of page B.4.

An additional course specifier is rated in the Schizophrenia/Delusional Disorder/Schizoaffective Disorder chronology section, which starts on page C.17.

11.7.6 Ratings for Brief Psychotic Disorder (C.13–C.14)

This diagnosis applies to psychotic episodes that last at least 1 day, but less than 1 month, and are not part of a mood disorder, any of the more specific psychotic disorders described above, or a Psychotic Disorder Due to Another Medical Condition or a Substance/Medication-Induced Disorder. Note that unlike Schizophreniform Disorder, which 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—thus providing confirmation of the brief duration.

SPECIFIERS FOR BRIEF PSYCHOTIC DISORDER

WITH AND WITHOUT MARKED STRESSORS: This specifier allows the interviewer to indicate whether or not the symptoms occur in response to a stressful event.

WITH PERIPARTUM ONSET: This specifier allows the interviewer to indicate that the symptoms had their onset within 4 weeks postpartum.

WITH CATATONIA: This specifier applies if the DSM-5 criteria (pp. 119–120) for the catatonia syndrome are met, which require that the current clinical picture be dominated by at least three catatonic symptoms that were rated "3" on SCID-5 pages B.7–B.8. Because these symptoms were rated for lifetime, it might be necessary to recheck to see if they are present during the current episode of illness.

11.7.7 Ratings for Other Specified Psychotic Disorder (C.15–C.16)

The paragraph defining this disorder in DSM-5 (p. 122) has been converted into a set of four ratings included in the SCID-5. Note that the name of this category is "Other Specified Schizophrenia Spectrum and Other Psychotic Disorder" in DSM-5 but was simplified for the purposes of the SCID.

Symptoms characteristic of a Schizophrenia Spectrum and Other Psychotic Disorder: This category is intended for presentations "characteristic" of a Schizophrenia Spectrum and Other Psychotic Disorder that predominate the clinical picture—i.e., abnormalities in one of the five domains that define Schizophrenia Spectrum and Other Psychotic Disorders: delusions, hallucinations, disorganized speech, disorganized or abnormal motor behavior, and negative symptoms.

Symptoms cause clinically significant distress or impairment: This item clarifies that all of the DSM-5 Other Specified categories must meet the basic requirement that the symptoms be sufficiently severe as to have a negative impact on the subject's life.

Not due to a GMC and not substance/medication-induced: This item instructs the interviewer to consider and rule out a GMC or a substance/medication as an etiological factor for the psychotic symptoms, in which case a Psychotic Disorder Due to Another Medical Condition or Substance/Medication-Induced Psychotic Disorder is diagnosed. Note that the descriptions of Other Specified (and Unspecified) Psychotic Disorders in DSM-5 do not specifically require general medical or substance/medication etiologies be ruled out. The requirement to rule out such etiologies has been added to the SCID-5-RV to ensure that subthreshold presentations due to a GMC or substance/medication get properly diagnosed. See Section 10, "Differentiating General Medical and Substance/Medication Etiologies From Primary Disorders," in this User's Guide for a general discussion of how to apply this criterion, as well as how to assess the criteria for Psychotic Disorder Due to Another Medical Condition and Substance/Medication-Induced Psychotic Disorder.

Indication of the type of symptomatic presentation: The list of examples in DSM-5 of presentations (supplemented by three additional SCID-specific examples) that can be specified using the Other Specified designation is included here. For specified psychotic presentations not covered by one of these examples, the "other" designation should be used, in which case the interviewer should record the specific reason that the criteria for one of the Schizophrenia Spectrum and Other Psychotic Disorders were not met. For presentations in which there is insufficient information to make a more specific diagnosis, Unspecified Type should be recorded.

11.7.8 Chronology for Schizophrenia, Delusional Disorder, and Schizoaffective Disorder (C.17–C.18)

After making a diagnosis of Schizophrenia, Delusional Disorder, or Schizoaffective Disorder, the interviewer is directed to this Chronology section.

For each of these disorders, the first step is to determine whether or not the disorder should be considered current—a decision for which no explicit guidance is provided in DSM-5. Requiring that the full criteria be met for the past month (as for other disorders in the SCID-5), does not apply to the Psychotic Disorders. Full threshold psychotic symptoms should not be required for an entire month to be considered a current Psychotic Disorder—any clinically significant psychotic symptoms in the past month should suffice. After consultation with the DSM-5 Psychotic Disorders Work Group, the following disorder-specific criteria indicative of active illness have been adopted in the SCID:

1) **Schizophrenia** is considered *current* if active phase criteria are met for any duration in the past month.
2) **Delusional Disorder** is considered *current* if delusions are present at any time in the past month.
3) **Schizoaffective Disorder** is considered *current* if EITHER symptoms meeting criteria for an MDE or a Manic Episode (except for duration) are concurrent with symptoms meeting Criterion A of Schizophrenia at some point in the past month OR there have been delusions or hallucinations in the absence of an MDE or a Manic Episode in the past month.

If criteria are not met for "current," the interviewer is instructed to indicate the length of time (in months) since full criteria for Schizophrenia, Delusional Disorder, or Schizoaffective Disorder were last met. The interviewer is next asked to determine age at first onset of psychotic symptoms, and then the age at onset of prodromal symptoms.

Lastly, the interviewer is asked to indicate the course specifier that is most appropriate for describing the longitudinal course of the disorder over the subject's lifetime. These longitudinal course specifiers only apply after a 1-year duration of the disorder (i.e., only if the onset is at least 1 year ago). Note that a modified version of the DSM-5 longitudinal course specifiers has been included in the SCID-5-RV in order to operationalize the minimum required durations of periods of current remission and inter-episode remission. Thus, after consultation with members of the DSM-5 Psychotic Disorders Work Group, **a 1-month minimum duration** has been adopted as a requirement for being In Partial Remission (i.e., a period of time lasting at least 1 month during which an improvement after a previous episode is maintained and in which the defining criteria of the disorder are only partially fulfilled) and for being currently In Full Remission (i.e., a period of time lasting at least 1 month after a previous episode, during which no disorder-specific symptoms are present). These course specifiers apply to both first episode and multiple episodes. The occurrence of psychotic symptoms is considered to represent a new episode when at least 3 months have elapsed with no more than subthreshold (or absent) symptoms. Finally, the definition of the Continuous course specifier has been modified to correct an error. The original DSM-5 definition (i.e., "symptoms fulfilling the diagnostic symptom criteria of the disorder are remaining for the majority of the illness course, with subthreshold symptom periods being very brief relative to the overall course") was internally inconsistent. The requirement that the symptoms be present for only the "majority of the illness course" allows for considerably more periods of subthreshold symptoms than is indicated by the remainder of the statement that these be "very brief relative to the overall course." The SCID fixes this by now requiring that the symptoms fulfilling the symptom criteria be present for almost all of the illness course.

11.7.9 Chronology for Schizophreniform Disorder, Brief Psychotic Disorder, Psychotic Disorder Due to Another Medical Condition, Substance/Medication-Induced Psychotic Disorder, and Other Specified Psychotic Disorder (C.19–C.20)

After making a diagnosis of Schizophreniform Disorder, Brief Psychotic Disorder, Psychotic Disorder Due to Another Medical Condition, Substance/Medication-Induced Psychotic Disorder, or Other Specified Psychotic Disorder, the interviewer is directed to this Chronology section.

The first step is to determine, for each of these disorders, whether or not the disorder should be considered current, a decision for which no explicit guidance is provided in DSM-5. After consultation with the DSM-5 Psychotic Disorders Work Group, the following disorder-specific criteria indicative of active illness have been adopted in the SCID:

1) **Schizophreniform Disorder** is considered *current* if active phase criteria are met for any duration in the past month.
2) **Brief Psychotic Disorder** is considered *current* if delusions, hallucinations, or disorganized speech are present at some point in the past month.
3) **Psychotic Disorder Due to Another Medical Condition** or **Substance/Medication-Induced Psychotic Disorder** is considered *current* if there have been delusions or hallucinations during the past month.
4) **Other Specified Psychotic Disorder** is considered *current* if there have been psychotic symptoms in the past month.

If criteria are not met for "current," the interviewer is instructed to indicate the length of time (in months) since full criteria for Schizophreniform Disorder, Brief Psychotic Disorder, Psychotic Disorder Due to Another Medical Condition, or Substance/Medication-Induced Psychotic Disorder were last met; or for Other Specified Psychotic Disorder, the number of months since psychotic symptoms were last present.

11.7.10 Ratings for Psychotic Disorder Due to Another Medical Condition and Substance/Medication-Induced Psychotic Disorder (C.21–C.24)

These final sections of Module C are consulted only in the course of evaluating the organic rule-out criterion that is included in the criteria sets for Schizophrenia, Schizophreniform Disorder, Schizoaffective Disorder, Delusional Disorder, Brief Psychotic Disorder, and Other Specified Psychotic Disorder. The SCID-5 rule is that if there is any indication that a drug of abuse, medication, or a GMC 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. See Section 10, "Differentiating General Medical and Substance/Medication Etiologies From Primary Disorders," in this User's Guide for a general discussion of how to assess the criteria for these disorders.

11.8 Module D. Differential Diagnosis of Mood Disorders

Whereas Module A is for rating Major Depressive, Manic, and Hypomanic Episodes, Module D is for recording Bipolar I Disorder, Bipolar II Disorder, Other Specified Bipolar Disorder, Major Depressive Disorder, and Other Specified Depressive Disorder. The interviewer should go through Module D if EITHER of the following applies: 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 these symptoms are not merely an associated feature of a psychotic disorder (e.g., not just mild depressive symptomatology occurring during the residual phase of Schizophrenia (from Module C). As in Module C, the task in Module D is to evaluate whether the specific criteria for Mood Disorders are met based on information gathered in Modules A, B, and C.

11.8.1 Ratings for Bipolar I Disorder (D.1)

Criterion A—At least one Manic Episode: The minimum requirement for a diagnosis of Bipolar I Disorder is one Manic Episode during the subject's lifetime. Thus, this item is rated "3" if there has been either a current Manic Episode or a past Manic Episode in Module A.

Criterion B—The occurrence of the mood episodes is not better explained by Schizoaffective Disorder or another psychotic disorder: If a psychotic disorder has already been diagnosed in Module C, a comorbid diagnosis of Bipolar I Disorder depends on whether diagnostic symptoms occurred *in addition to* Schizoaffective Disorder or another psychotic disorder. Given that the presence of a Manic Episode is a part of the definition of Schizoaffective Disorder, Manic Episodes occurring in the context of a diagnosis of Schizoaffective Disorder are considered to be "explained" by the Schizoaffective Disorder and do not count toward a diagnosis of Bipolar I Disorder. The interpretation of "better explained by" as it applies to other psychotic disorders, like Schizophrenia and Delusional Disorder, is less clear. The DSM-IV version of this criterion treated Schizoaffective Disorder and the other psychotic disorders differently, excluding a diagnosis of Bipolar I Disorder if the Manic Episodes were "superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified." This had been interpreted as not counting Manic Episodes toward a diagnosis of Bipolar I Disorder if they occurred during the course of a psychotic disorder, necessitating a diagnosis of Bipolar Disorder Not Otherwise Specified in order to indicate superimposed Manic Episodes. The use of "better explained by" in place of "superimposed on" (and the absence of any DSM-5 text indicating otherwise) suggests that in DSM-5, Manic Episodes occurring during a psychotic disorder other than Schizoaffective Disorder should count toward a diagnosis of Bipolar I Disorder, thus justifying comorbid diagnoses of both the psychotic disorder and Bipolar I Disorder.

Type of current (or most recent) episode: The evaluation of Bipolar I Disorder concludes with the interviewer rating the type of the current episode (or most recent episode, if Bipolar I Disorder is in remission). Note that if criteria are met simultaneously for both a Manic Episode and an MDE, the current (or most recent) episode is considered to be Manic.

11.8.2 Ratings for Bipolar II Disorder (D.2–D.3)

Criterion A—At least one Hypomanic Episode and at least one MDE: The minimum requirement for a diagnosis of Bipolar II Disorder is one Hypomanic Episode and one MDE during the subject's lifetime. Thus, this item is rated "3" if there has ever been a current or past MDE as well as a current or past Hypomanic Episode in Module A.

Criterion B—Never any Manic Episodes: Although the Module D skip pattern should prevent the interviewer from getting to page D.2 if there have ever been any Manic Episodes, this item is retained just to be sure.

Criterion C—The occurrence of the Hypomanic Episode and MDE is not better explained by Schizoaffective Disorder or another psychotic disorder: If a psychotic disorder has already been diagnosed in Module C, a comorbid diagnosis of Bipolar II Disorder depends on whether diagnostic symptoms occurred *in addition to* Schizoaffective Disorder or another psychotic disorder. Given that the presence of an MDE is a part of the definition of Schizoaffective Disorder, MDEs occurring in the context of a diagnosis of Schizoaffective Disorder are considered to be "explained" by the Schizoaffective Disorder and do not count toward a diagnosis of Bipolar II Disorder. The interpretation of "better explained by" as it applies to other psychotic disorders, like Schizophrenia and Delusional Disorder, is less clear. The DSM-IV version of this criterion treated Schizoaffective Disorder and the other psychotic disorders differently, excluding a diagnosis of Bipolar II Disorder if the Hypomanic Episode and MDE were "superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified." This had been interpreted as not counting Hypomanic Episodes and MDEs toward a diagnosis of Bipolar II Disorder if they occurred during the course of a psychotic disorder, necessitating a diagnosis of Bipolar Disorder Not Otherwise Specified in order to indicate superimposed Hypomanic Episodes and MDEs. The use of "better explained by" in place of "superimposed on" (and the absence of any DSM-5 text indicating otherwise) suggests that in DSM-5, Hypomanic Episodes and MDEs occurring during a psychotic disorder other than Schizoaffective Disorder should count toward a diagnosis of Bipolar II Disorder, thus justifying comorbid diagnoses of both the psychotic disorder and Bipolar II Disorder.

Criterion D—Depression or unpredictability causes distress or impairment: In Bipolar II Disorder, the requisite clinically significant distress or impairment can arise either from the MDEs themselves, which are often quite severe, or from the unpredictability of the alternation between depression and hypomania. The Hypomanic Episodes by themselves do not cause distress or impairment.

SPECIFIERS FOR BIPOLAR I AND BIPOLAR II DISORDER

WITH RAPID CYCLING: DSM-5 defines Rapid Cycling as four mood episodes in the past 12 months, each meeting the full criteria for severity and duration. Note that the skip pattern in Module A allows for detailed ratings for at most one MDE, Manic Episode, or Hypomanic Episode (either current or past); thus, information as to whether there have been four full syndrome episodes in the past 12 months may be lacking. Those investigators interested in a precise assessment of Rapid Cycling should undertake a more detailed review of past episodes occurring in the last year.

WITH SEASONAL PATTERN: The essential feature of this specifier is a "regular" seasonal pattern of at least one type of episode (i.e., MDE, Manic Episode, or Hypomanic Episode); thus, this specifier only needs to be assessed if the subject has had a lifetime history of at least two MDEs or at least two Manic

or Hypomanic Episodes—hence, the initial skip instruction. (Criteria for this specifier are discussed below.)

Criterion A—Regular temporal relationship of onset: The interviewer first asks a general question about whether elevated, irritable, or depressed mood seems to occur mostly at the same time of the year. Then the interviewer asks more precisely about which month the symptoms typically start; information that should be recorded beneath Criterion A for this specifier. **Note:** The phrase "mostly seem to happen" is used to reflect the fact that not all episodes of the same polarity need to occur at the same time of the year. Criterion D for this specifier (see below) requires only that the seasonal episodes "substantially outnumber" the nonseasonal episodes.

Criterion B—Regular temporal relationship of remission: In order to qualify for this specifier, remissions (or a change in polarity) must occur at the same time of the year. The interviewer needs to determine the month during which this usually happens and records it below Criterion B for this specifier.

Criterion C—Pattern evident in past 2 years: This criterion establishes that the seasonal pattern of MDEs, Manic Episodes, or Hypomanic Episodes established in Criteria A and B for this specifier was evident during the past 2 years—meaning that all episodes of a particular type follow the seasonal pattern and there are no episodes of that type occurring outside the seasonal pattern.

Criterion D—Lifetime seasonal episodes substantially outnumber lifetime nonseasonal episodes: This item requires a consideration of the lifetime pattern of episodes of the type that was identified as being seasonal in Criteria A and B for this specifier. For Criterion D to be met, seasonal episodes must substantially outnumber nonseasonal episodes. No specific guidance is provided in DSM-5 regarding the required ratio of seasonal to nonseasonal episodes.

11.8.3 Ratings for Other Specified Bipolar Disorder (D.6–D.8)

If there are symptoms characteristic of a Bipolar and Related Disorder that do not meet criteria for Bipolar I Disorder, Bipolar II Disorder, Cyclothymic Disorder, or the With Mixed Features specifier in the context of an MDE, then Other Specified Bipolar Disorder should be considered. The paragraph defining this disorder in DSM-5 (p. 148) has been converted into a set of four ratings in the SCID-5.

Symptoms characteristic of a Bipolar and Related Disorder: This item indicates that this category is intended for presentations that include periods of prominent elevated, euphoric, or irritable mood that do not meet criteria for one of the Bipolar and Related Disorders (i.e., Bipolar I Disorder, Bipolar II Disorder, or Cyclothymic Disorder) or for the With Mixed Features specifier in the context of an MDE. Note that the exclusion of cases that meet criteria for the With Mixed Features specifier from the diagnosis of Other Specified Bipolar Disorder is not part of the actual DSM-5 definition of Other Specified Bipolar Disorder; hence, this phrase is surrounded by brackets. We believe this to be an unintentional omission in DSM-5. Otherwise, cases of Major Depressive Disorder With Mixed Features could qualify for a diagnosis of Other Specified Bipolar Disorder, because such cases include symptoms characteristic of a Bipolar and Related Disorder.

Symptoms cause clinically significant distress or impairment: This item clarifies that all of the DSM-5 Other Specified categories must meet the basic requirement that the symptoms be sufficiently severe as to have a negative impact on the subject's life.

Not due to a GMC and not substance/medication-induced: This item instructs the interviewer to consider and rule out a GMC or a substance/medication as an etiological factor for the bipolar and related symptoms, in which case a Bipolar and Related Disorder Due to Another Medical Condition or Substance/Medication-Induced Bipolar and Related Disorder is diagnosed. Note that the descriptions of Other Specified (and Unspecified) Bipolar and Related Disorders in DSM-5 do not specifically require that general medical or substance/medication etiologies be ruled out. The requirement to rule out such etiologies has been added to the SCID-5-RV to ensure that subthreshold presentations due to a GMC or substance/medication get properly diagnosed. See Section 10, "Differentiating General Medical and Substance/Medication Etiologies From Primary Disorders," in this User's Guide for a general discussion of how to apply this criterion, as well as how to assess the criteria for Bipolar and Related Disorder Due to Another Medical Condition and Substance/Medication-Induced Bipolar and Related Disorder.

Indication of the type of symptomatic presentation: The list of examples in DSM-5 of presentations that can be specified using the Other Specified designation (supplemented by four additional SCID-specific examples) is included. SCID-specific example 5 is for manic-like episodes at full symptom threshold (i.e., at least three out of seven associated symptoms) with a duration of less than 1 week (thus not meeting criteria for a Manic Episode), but causing significant functional impairment (thus not meeting criteria for a Hypomanic Episode). For specified bipolar presentations not covered by one of these examples, the "other" designation should be used, in which case the interviewer should record the specific reason that the criteria for one of the Bipolar and Related Disorders were not met. For presentations in which there is insufficient information to make a more specific diagnosis, Unspecified Type should be recorded.

11.8.4 Ratings for Major Depressive Disorder (D.9)

At least one MDE: The minimum requirement for a diagnosis of Major Depressive Disorder is one MDE during the subject's lifetime. No single criterion specifies this in the DSM-5 Major Depressive Disorder criteria set. The first three criteria in MDD are identical to Criteria A, B, and C of an MDE and thus have been combined into a single item in the SCID-5.

Criterion D—The occurrence is not better explained by Schizoaffective Disorder or another psychotic disorder: If a psychotic disorder has already been diagnosed in Module C, a comorbid diagnosis of Major Depressive Disorder depends on whether diagnostic symptoms occurred *in addition to* Schizoaffective Disorder or another psychotic disorder. Given that the presence of an MDE is a part of the definition of Schizoaffective Disorder, MDEs occurring in the context of a diagnosis of Schizoaffective Disorder are considered to be "explained" by the Schizoaffective Disorder and do not count toward a diagnosis of Major Depressive Disorder. The interpretation of "better explained by" as it applies to other psychotic disorders, like Schizophrenia and Delusional Disorder, is less clear. The DSM-IV version of this criterion treated Schizoaffective Disorder and the other psychotic disorders differently, excluding a diagnosis of Major Depressive Disorder if the MDEs were "superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified." This had been interpreted as not counting MDEs toward a diagnosis of Major Depressive Disorder if they occurred during the course of a psychotic disorder, necessitating a diagnosis of Depressive Disorder NOS in order to indicate superimposed MDEs. The use of "better explained by" in place of "superimposed on" (and the absence of any DSM-5 text indicating otherwise) suggests that in DSM-5, MDEs occurring during a psychotic disorder other than Schizoaffective Disorder should count toward a diagnosis of Major Depressive Disorder, thus justifying comorbid diagnoses of both the psychotic disorder and Major Depressive Disorder.

Criterion E—Never any Manic or Hypomanic Episodes: Although the Module D skip pattern should prevent the interviewer from getting to page D.9 if there have been any Manic or Hypomanic Episodes, this item is retained just to be sure.

Single Episode vs. Recurrent: Note that in order for Major Depressive Disorder to be considered recurrent, the interviewer needs only determine that there was a period lasting at least 2 months in which the depressive symptomatology consistently fell below the five-symptom threshold for an MDE (i.e., a partial remission); a 2-month period of full remission is not required to identify a "recurrence."

SPECIFIER FOR MAJOR DEPRESSIVE DISORDER

WITH SEASONAL PATTERN: The essential feature is a "regular" seasonal pattern of MDEs, which means this specifier only needs to be assessed if the subject has had a lifetime history of at least two MDEs. See pp. 107–108 of this User's Guide for additional details about assessment of the With Seasonal Pattern specifier in "SPECIFIERS FOR BIPOLAR I AND BIPOLAR II DISORDER."

11.8.5 Ratings for Other Specified Depressive Disorder (D.11–D.13)

Other Specified Depressive Disorder should be considered if there are symptoms characteristic of a Depressive Disorder (that do not meet criteria for another Depressive Disorder or Adjustment Disorder). The paragraph defining this disorder in DSM-5 (pp. 183–184) has been converted into a set of four ratings included in the SCID-5.

Symptoms characteristic of a Depressive Disorder: This item indicates that this category is intended for presentations that include periods of prominent depressed mood or loss of interest or pleasure that do not meet the full criteria for Major Depressive Disorder, Persistent Depressive Disorder (diagnosed in Module A), PMDD (diagnosed in Module A), Adjustment Disorder With Depressed Mood, or Adjustment Disorder With Mixed Anxiety and Depressed Mood (diagnosed in Module L). Note that the clause excluding Adjustment Disorder With Depressed Mood and Adjustment Disorder With Mixed Anxiety and Depressed Mood was mistakenly left out of DSM-5 and is included in the SCID-5. Given that Adjustment Disorder has not yet been diagnosed at this point in the SCID-5, the interviewer may have to return here and revise this rating if criteria are later met for Adjustment Disorder With Depressed Mood or With Mixed Anxiety and Depressed Mood.

Symptoms cause clinically significant distress or impairment: This item clarifies that all of the DSM-5 Other Specified categories must meet the basic requirement that the symptoms be sufficiently severe as to have a negative impact on the subject's life.

Not due to a GMC and not substance/medication-induced: This item instructs the interviewer to consider and rule out a GMC or a substance/medication as an etiological factor for the depressive symptoms, in which case a Depressive Disorder Due to Another Medical Condition or Substance/Medication-Induced Depressive Disorder is diagnosed. Note that the descriptions of Other Specified (and Unspecified) Depressive Disorders in DSM-5 do not specifically require that general medical or substance/medication etiologies be ruled out. The requirement to rule out such etiologies has been added to the SCID-5-RV to ensure that subthreshold presentations due to a GMC or substance/medication get properly diagnosed. See Section 10, "Differentiating General Medical and Substance/Medication Etiologies From Primary Disorders," in this User's Guide for a general discussion of how to apply this criterion, as well as how to

assess the criteria for Depressive Disorder Due to Another Medical Condition and Substance/Medication-Induced Depressive Disorder.

Indication of the type of symptomatic presentation: The list of examples in DSM-5 of presentations that can be specified using the Other Specified designation (supplemented by three additional examples specific to the SCID) is included. For depressive presentations not covered by one of these specific examples, the "other" designation should be used, in which case the interviewer should record the specific reason that the criteria for any of the Depressive Disorders were not met. For presentations in which there is insufficient information to make a more specific diagnosis, Unspecified Type should be recorded.

11.8.6 Ratings for Bipolar I and Bipolar II Disorder Chronology (D.14–D.16)

The interviewer is taken to this Chronology section after making a diagnosis of Bipolar I or Bipolar II Disorder. The first step is for the interviewer to determine whether symptomatic criteria are met for a Manic Episode, Hypomanic Episode, or MDE during the past month, in which case the Bipolar Disorder would be considered current. Note that at least the entire minimum required duration (i.e., 1 week for Manic Episode, 4 days for Hypomanic Episode, 2 weeks for an MDE) should have occurred within the past 4 weeks to be considered current. If an episode is current, then the interviewer continues with the severity specifiers for that episode on page D.15.

If criteria are not currently met for a mood episode, the interviewer is instructed to indicate the length of time (in months) since the subject last had persistently euphoric, irritable, or depressed mood. (The interviewer is not required to make the much more difficult determination of how long it has been since full criteria for a mood episode were met.) This is followed by a rating of the type of remission (i.e., In Partial Remission or In Full Remission) and the age at onset of the first mood episode that is considered to be a manifestation of the Bipolar Disorder. Partial Remission is indicated only if either some subthreshold symptoms of the most recent type of episode persist or there have been no symptoms at all for less than 2 months. Full Remission requires the absence of symptoms for at least 2 months.

SPECIFIERS FOR BIPOLAR I AND BIPOLAR II DISORDER

SEVERITY SPECIFIERS FOR CURRENT MANIC EPISODE: The SCID-5 severity specifiers differ from what appear in DSM-5. In DSM-5, the DSM-IV severity specifiers for an MDE have also been applied to a Manic Episode, so that the severity depends on a combination of the number of symptoms and the degree of impairment in functioning. However, by definition, even the mildest Manic Episode must be "sufficiently severe to cause *marked* impairment in social or occupational functioning" (i.e., Criterion C; author's italics added), whereas the "Mild" severity definition requires that "the symptoms result in *minor* impairment in social or occupational functioning" (DSM-5, p. 154; author's italics added). Therefore, the DSM-IV severity specifiers for a Manic Episode have been used instead.

WITH PSYCHOTIC FEATURES: If delusions or hallucinations have been present at any time during the current Manic Episode, this specifier applies and should be recorded. In such cases, the interviewer is asked to further specify whether the delusions or hallucinations are mood congruent or mood incongruent based on their theme. Note that the Mood Congruent specifier is given only if the thematic types of *all* of the delusions or hallucinations are mood congruent. If the thematic types are mixed (both mood congruent and mood incongruent), the Mood Incongruent specifier is used instead.

WITH PANIC ATTACKS: The final specifier indicates the presence of comorbid panic attacks. This specifier should be considered if there has been a history of panic attacks (pages F.1–F.2); criteria for Panic Disorder have never been met (pages F.2–F.5); panic attacks have occurred in the context of the current Manic Episode, Hypomanic Episode, or MDE (page F.7); and there has been at least one panic attack during the past month. Note that a 1-month time frame has been added to the SCID-5-5 as a way of operationalizing this specifier; no time frame or frequency requirement is included in DSM-5. The coding of this specifier may need to wait until after Panic Disorder is evaluated in Module F.

11.8.7 Ratings for Major Depressive Disorder Chronology (D.17)

The interviewer is taken to this Chronology section after making a diagnosis of Major Depressive Disorder. The first step is for the interviewer to determine whether symptomatic criteria are met for an MDE during the past month, in which case the Major Depressive Disorder is considered current. Note that at least the entire minimum required duration (i.e., 2 weeks for an MDE) should have occurred within the past 4 weeks to be considered current. If an episode is current, the interviewer follows the line down from the rating of "3" and then continues with the severity specifiers for the current episode.

If the episode is not current (criteria are not currently met for an MDE), the interviewer follows the line down from the rating of "1" and is then instructed to indicate the length of time (in months) since the subject last had persistently depressed mood. (The interviewer is not required to make the much more difficult determination of how long it has been since full criteria for an MDE were met.) This is followed by a rating of the type of remission (i.e., In Partial Remission or In Full Remission) and the age at onset of the first MDE. Partial Remission is indicated if either some subthreshold symptoms of an MDE persist or else there have been no symptoms at all for less than 2 months. Full Remission requires the absence of symptoms for at least 2 months.

SPECIFIERS FOR MAJOR DEPRESSIVE DISORDER

SEVERITY SPECIFIERS FOR CURRENT MDE: These severity specifiers require consideration of the number of symptoms, their manageability, and their impact on the subject's functioning. A severe MDE is characterized by symptoms exceeding the threshold of five out of nine symptoms; the symptoms are distressing and unmanageable; and they markedly interfere with functioning.

WITH PSYCHOTIC FEATURES: If delusions or hallucinations have been present at any time during the current MDE, this specifier should be designated. The interviewer is asked to further specify whether the delusions or hallucinations are mood congruent or mood incongruent based on their theme. Note that the Mood Congruent specifier is given only if the thematic types of *all* of the delusions or hallucinations are mood congruent. If the thematic types are mixed (both mood congruent and mood incongruent), the Mood Incongruent specifier is used instead.

WITH PANIC ATTACKS: This final specifier indicates the presence of comorbid panic attacks. This specifier should be considered if there has been a history of panic attacks (pages F.1–F.2); criteria for Panic Disorder have never been met (pages F.2–F.5); panic attacks have occurred in the context of the current MDE (page F.7); and there has been at least one panic attack during the past month. Note that a 1-month time frame has been added to the SCID-5 as a way of operationalizing this specifier; no time frame or frequency requirement is included in DSM-5. The coding of this specifier may need to wait until after Panic Disorder is evaluated in Module F.

11.9 Module E. Substance Use Disorders

This module contains ratings for the Substance Use Disorders, which cover problems caused by the subject's pattern of substance use. The SCID-5 separates the evaluation of Alcohol Use Disorder from the other Substance Use Disorders because alcohol is legal, it is more widely used than other substances, and most users do not have problems with it. Psychiatric symptoms (e.g., psychosis, depression, anxiety) related to the direct effects of the substance on the central nervous system are diagnosed as Substance/Medication-Induced Disorders and are located throughout the SCID-5 according to the type of symptom presentation (i.e., Substance/Medication-Induced Depressive Disorder and Substance/Medication-Induced Bipolar Disorder in Module A, Substance/Medication-Induced Psychotic Disorder in Module C, Substance/Medication-Induced Anxiety Disorder in Module F, Substance/ Medication-Induced Obsessive-Compulsive and Related Disorder in Module G, and Substance/ Medication-Induced Sleep Disorder in optional Module H).

Module E first assesses Alcohol Use Disorder for the past 12 months because of the requirement that at least two items occur "within a 12-month period" to meet criteria for the disorder. Alcohol Use Disorder occurring before the past 12 months is assessed only if criteria are not met for Alcohol Use Disorder in the past year.

11.9.1 Ratings for Past-12-Month Alcohol Use Disorder (E.1–E.5)

Because the last section of the Overview focused on current and past alcohol and other drug use, the interviewer should already have a rough idea of the subject's current and past history of alcohol use when starting the Alcohol Use Disorder section. Two questions about current drinking habits were included in the Other Current Problems section of the Overview (page 6 in the Patient Version and page 4 in the Nonpatient Version)—i.e., "In the past month, how much have you been drinking?" and "When you drink, who are you usually with? (Are you usually alone or out with other people?" Furthermore, the Lifetime Alcohol Use section in the Overview (the bottom half of page 6 in the Patient Version and page 4 in the Nonpatient Version) includes four additional questions (some with suggested follow-up questions) inquiring about the subject's lifetime drinking history: "How much do you usually drink?" "Over your lifetime, when were you drinking the most? (During that time, how much were you drinking? What were you drinking? Beer? Wine? Hard liquor? How often were you drinking this much?)" "Have you ever had a time when your drinking caused problems for you?" and "Have you ever had a time when anyone objected to your drinking?"

With the answers to these Overview questions as background, the interviewer starts the Past-12-Month Alcohol Use Disorder evaluation by deciding whether it makes sense to skip over the evaluation because of the lack of any evidence suggesting the possibility of an Alcohol Use Disorder in the past 12 months. First, if the subject credibly denies ever having used alcohol in his or her life, then the interviewer should skip to the assessment of Nonalcohol Substance Use Disorders on page E.10. If the subject acknowledges having ever used alcohol, the interviewer follows up with a question to determine whether the subject's past-12-month alcohol use exceeds a minimum threshold (i.e., having drunk alcohol at least six times in the past 12 months), below which an Alcohol Use Disorder is unlikely to have occurred. Note that this question is not inquiring about the number of drinks in the past year, but the number of *times* (i.e., "drinking events") that the subject has used alcohol. On the low end, such a drinking event could consist of only one drink (e.g., having a glass of wine at dinner or at a bar with friends) but on the extreme end could consist of a night of binge drinking at a college fraternity party during which many drinks are consumed. If the subject's reported use is credibly below the threshold of

six times in a year, then the interviewer is allowed to skip to the evaluation of Prior-to-Past-12-Month Alcohol Use Disorder on page E.6. The standard SCID rule regarding skip-outs applies here in particular: when in doubt, do not skip out!

Alcohol (and other Substance) Use Disorders are characterized by a problematic pattern of alcohol or substance use, leading to clinically significant impairment or distress, as indicated by 2 or more of the following 11 items in Criterion A occurring within a 12-month period. The parenthetical examples included with many of these items in DSM-IV have been included in the SCID-5 to assist the interviewer in making reliable ratings.

Criterion A1—Larger amounts/longer periods than intended: 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"; "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 stays in the bar for several hours) must occur OFTEN in order to be coded "3." There is something of a paradox inherent in the evaluation of Criterion A1 (and Criterion A2 as well). In order to qualify for these items, the individual must have developed enough insight about having a drinking problem (or wanted to avoid developing a drinking problem) to want to control his or her drinking. It is therefore not possible to rate Criterion A1 as "3" in someone who has a very heavy pattern of use but denies any need or desire to control or cut down use.

Criterion A2—Persistent desire or failed efforts to cut down/control substance use: This item is rated "3" under two circumstances. First, if the subject has had a persistent desire to stop, cut down, or control drinking, presumably because of self-awareness that his or her drinking has been problematic in some way, a rating of "3" would apply. Although DSM-5 leaves the definition of "persistent" up to clinical judgment, a period lasting at least 1 month in which the person's desire to cut back or control drinking occurred for most of the time would be reasonable to count as "persistent." Second, in cases in which the subject does not have a persistent desire to cut down or control drinking but nonetheless has tried unsuccessfully to do so (e.g., in response to repeated demands from family members), a rating of "3" would also apply. Note that for an effort to cut down or control drinking to be considered "successful" (and justify a rating of "1"), the period of controlled or diminished use must have lasted for an extended period of time (e.g., months or years).

Criterion A3—Great deal of time spent on substance use: This three-part item covers the various ways in which drinking may become a central focus of the subject's life: time spent obtaining alcohol, time spent drinking and being intoxicated, and time spent recovering from its effects. 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 is advisable to establish in advance specific study-wide rules (e.g., at least 4 hours per day for most days). As a rule of thumb, two evenings a week spent drinking is not "a great deal of time" and would justify a rating of "2" at best; most evenings a week with next-day hangovers would justify a rating of "3."

Criterion A4—Craving: This criterion is met if there has been a strong urge or desire to use alcohol when not drinking. The intensity threshold for craving should be such that the craving has some negative impact on the person. For example, the urge to drink might be so strong that the subject has trouble thinking about anything else, or the urge to drink results in significant discomfort or greatly weakens the subject's resolve to cut back on or quit drinking alcohol. In some subjects, the urge to drink is associated with specific cues, like going into a bar or running into a drinking buddy on the street. In order to explore this possibility, the follow-up question asks whether the craving is associated with certain situations.

Criterion A5—Recurrent failure to fulfill obligations at work, school, and/or home: A rating of "3" for this item requires specific evidence that the effects of the alcohol use (i.e., intoxication, withdrawal, or "hangover") resulted in the subject's failure to fulfill a major role obligation on at least two occasions. The accompanying examples illustrate the wide range of the types of activities that may be affected: repeated absences from work or poor work performance; absences, suspensions, or expulsions from school; and neglect of children or household responsibilities. Note that simply being intoxicated while at work, at school, or taking care of children without apparent impairment is not sufficient to justify a rating of "3"; there must be some evidence that the effects of alcohol significantly and recurrently interfered with functioning in one of these domains.

Criterion A6—Continued use despite recurrent interpersonal problems as a result of alcohol use: Like Criterion A5, Criterion A6 reflects social or interpersonal problems that are caused by the effects of drinking, such as marital strain caused by arguments or physical fights that occurred during a period of intoxication. Unlike Criterion A5, a rating of "3" requires that the subject continue to use alcohol despite these problems. Criterion A6 is difficult to evaluate when the interpersonal conflict is possibly attributable to an underlying relational problem rather than to the individual's alcohol use. For example, continued drinking despite arguments about occasional nonproblematic drinking that are initiated by a spouse who is against any drinking at all and with whom the subject has had recurrent marital strain involving other issues would not warrant a rating of "3."

Criterion A7—Important activities given up at work, school, or home so that time can be spent on substance use: The prototypical subject qualifying for this item is a "street-corner alcoholic," who has essentially given up all activities except those associated with drinking. However, it may also be applied, for example, to an amateur athlete who has stopped sports activities because of drinking or to a person who has stopped seeing all her friends so she can stay home and drink.

Criterion A8—Recurrent use in physically hazardous situations: 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 if the alcohol use caused sufficient impairment in coordination or cognition to create a physically hazardous condition (e.g., driving or hunting while intoxicated). To facilitate a proper inquiry, the first question simply establishes that the subject has drunk alcohol before engaging in an activity that requires coordination and concentration. If the subject acknowledges such use, the follow-up question then establishes whether the subject was in fact impaired to a degree that someone could have been injured as a result of the impaired coordination or concentration. Clinical judgment is necessary when interpreting the diagnostic significance of the subject's answers. The interviewer must balance variability in how much a given subject may be impacted by a given amount of alcohol due to tolerance and subjects' tendencies to minimize the impact of alcohol on their coordination and cognition. If a subject acknowledges consuming a great deal of alcohol in a short period of time and yet denies any impact on his or her functioning as a result, the interviewer might be justified in "overriding" the subject's negative response and concluding that he or she was in fact impaired, depending on the amount consumed and the person's level of tolerance.

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 act would warrant a rating of "3." The intent of Criterion A8 is to rate behavior that puts the subject or others in immediate danger because his or her coordination or cognition is impaired by drinking.

Criterion A9—Continued use despite knowledge that physical or psychological problems are caused or made worse by the alcohol: Like Criterion A6, 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. Consequently, in order to qualify for a rating of "3" on this item, the subject must first acknowledge understanding that the physical or psychological problems that he or she is experiencing are caused by drinking, and that despite this knowledge, he or she has continued to drink. Examples of physical problems include cirrhosis or esophageal bleeding due to excessive drinking; examples of psychological problems are "blackouts" (memory loss for events that occurred while intoxicated), alcohol-induced depression, or rebound anxiety the day after a heavy drinking episode. The most frequent noxious physical effect of alcohol is a hangover. When hangovers are severe and frequent, and the subject still continues to drink regularly, a rating of "3" is justified.

Criterion A10—Tolerance: Tolerance is the need for a person to drink greater amounts of alcohol to get the same effect as when that person first started drinking. Although Criterion A10 requires the need for "markedly increased amounts," how much the amount needs to have increased is left up to clinical judgment. The DSM-III-R version of the tolerance criterion specified at least a 50% increase, but this requirement was dropped from DSM-IV because it was felt to be pseudoprecise. Any adult who drinks regularly has somewhat higher tolerance than when they were typical adolescents experimenting with alcohol. This item is intended to capture those whose tolerance has increased markedly (e.g., "I used to get drunk on three beers—now I can drink two six-packs and not be drunk").

Criterion A11—Withdrawal: Withdrawal is indicated by the development of the characteristic alcohol 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 or taking a sedative in anticipation of the onset of withdrawal symptoms. For this reason, if the subject denies having had withdrawal symptoms, the interviewer asks whether or not the subject has ever started the day with a drink or else drank or took some other medication to avoid getting sick from withdrawal. Note that for part (a) of Criterion A11, which is a paraphrased version of Criterion B from DSM-5 Alcohol Withdrawal, at least two symptoms must develop within several hours to a few days after the cessation of (or reduction in) alcohol use. Two or more of the symptoms do not necessarily need to occur at the same time. As the criteria for Alcohol Withdrawal suggest, the course of development of withdrawal symptoms varies according to the symptom, the typical amount of alcohol consumed, and individual differences.

Meeting Criterion A for Alcohol Use Disorder: The presence of at least two of the above Criterion A symptoms during the past 12 months is sufficient to meet criteria for Past-12-Month Alcohol Use Disorder. If this minimum threshold is met, severity specifiers (Mild, Moderate, and Severe) are also assigned based on the number of items that have been present during the past 12 months, and the interviewer continues with the Past-12-Month Alcohol Use Chronology section.

11.9.2 Ratings for Past-12-Month Alcohol Use Chronology (E.5)

This SCID chronology section allows the interviewer to indicate on the Summary Score Sheet whether the disorder is current. The period of time designated as current in the SCID-5 usually reflects the time frame during which the criteria are applied. In the case of Substance Use Disorders, the DSM-5 criteria require that at least two items be present during the same 12-month period. Adopting such a broad time frame for current Substance Use Disorders in the SCID-5, however, would allow a designation of "current" to apply, for example, to a subject who had two items present 11 months ago but who then remained abstinent for the subsequent 11 months. Because DSM-5 considers early remission to have occurred if the subject is abstinent for 3 months, this hypothetical subject with current Alcohol Use Disorder would in fact be in early remission according to DSM-5. For these reasons, the SCID has

adopted **3 months** as the time frame for current, reflecting the 3-month interval in the DSM-5 definition of early remission. Therefore, if any alcohol use symptoms are present (other than craving) during the past 3 months in a subject for whom full criteria have been met during the past year, the Alcohol Use Disorder is considered to be current. Note that for both the current time frame and the remission specifiers, the craving item is considered to be an exception (i.e., the presence of craving does not count toward the requirement for being current, nor does it count against the subject qualifying for the In Remission specifier). This is because craving is the only item in Alcohol Use Disorder that does not require the subject to be actively using alcohol. Craving can in fact last for many years after abstinence, especially when triggered by environmental cues that remind the subject of his or her drinking days. For this reason, the presence of craving does not have the same symptomatic relevance as the other criteria items when it comes to determining remission status.

If there have not been any Alcohol Use Disorder symptoms in the past 3 months, then the interviewer needs to first indicate how many months it has been since the subject had any symptoms of an Alcohol Use Disorder (except for craving). If the subject is currently in a controlled environment, the interviewer should indicate that the specifier In a Controlled Environment applies, because the significance of the period of current remission may be limited by the fact that the person has had only restricted access to alcohol during that time. Finally, In Early Remission is indicated when none of the criteria for Alcohol Use Disorder (except craving) have been present for at least the past 3 months but for less than 12 months. The In Sustained Remission specifier is not offered here as an option because this specifier requires that no criteria for Alcohol Use Disorder have been met for at least the past 12 months, and this chronology section is for a diagnosis of Alcohol Use Disorder occurring within the past 12 months.

For the sake of efficiency, the standard flow through the SCID-5 skips the assessment of Alcohol Use Disorder for the period *before* the past 12 months (i.e., the rest of the subject's lifetime) if full criteria are met for Alcohol Use Disorder in the past 12 months. The interviewer then continues with the assessment of Past-12-Month Nonalcohol Substance Use Disorder on page E.12. For most studies, knowing that criteria have been met for a Substance Use Disorder and the age at onset are sufficient. However, one drawback to skipping this lifetime evaluation of Alcohol Use Disorder is that thus far the interviewer has not had an opportunity to determine the severity of the Alcohol Use Disorder *before* the past 12 months. Symptoms before the past 12 months might be considerably more severe than the symptoms of the past 12 months, as the course of Alcohol Use Disorder can wax and wane over the subject's lifetime. For those interviewers interested in assessing the lifetime severity of Alcohol Use Disorder before the past 12 months, the skip instruction in the box at the bottom of page E.5 should be suspended, and the interviewer should continue with the lifetime evaluation of Alcohol Use Disorder, as indicated in the note (ratings for prior-to-past-12-month Alcohol Use Disorder are discussed in the next section).

11.9.3 Ratings for Prior-to-Past-12-Month Alcohol Use Disorder (E.6–E.9)

If criteria are not met for Alcohol Use Disorder in the past 12 months as noted above, the interviewer then decides whether to evaluate for a history of Alcohol Use Disorder occurring before the past 12 months or to skip to the evaluation of Other Substance Use Disorders. If there is any suggestion of excessive or problematic alcohol use in the subject's lifetime based on the Lifetime Alcohol Use questions in the Overview, the interviewer should proceed with this section (rating symptoms of Alcohol Use Disorder before the past 12 months). If the subject's alcohol use history appears to be nonproblematic and has not been characterized by excessive use, the interviewer should check to see if the subject's alcohol use is below the threshold used in Past-12-Month Alcohol Use Disorder—i.e., "drinking six times in a 12-month period." If so, the interviewer is allowed to skip to the assessment of

Other Substance Use Disorders. If not, the evaluation continues with the questions for Alcohol Use Disorder as it applies to the period before the past 12 months.

To evaluate lifetime alcohol use (i.e., before the past 12 months), the interviewer must first select a 12-month time frame to use for evaluating the cluster of 11 Criterion A items for Alcohol Use Disorder (akin to the 2-week time frame that is needed to determine the clustering of items for past MDE). This time frame should be selected with the goal of maximizing the likelihood of meeting criteria for Alcohol Use Disorder and should be based on when in the person's life he or she has been drinking the most and when drinking caused the most problems, which should be known to the interviewer based on the answers to these questions provided in the Overview on page 6 in the Patient Version (and page 4 in the Nonpatient Version). Each of the 11 questions is thus framed in terms of whether that criterion was present during the 12-month time frame in question.

11.9.4 Ratings for Prior-to-Past-12-Month Alcohol Use Chronology (E.9)

This section is for rating the remission specifiers and age at onset of the Alcohol Use Disorder occurring before the past 12 months. The interviewer first indicates whether the subject is in a controlled environment (i.e., if the individual is currently in an environment where access to alcohol is restricted) and the *current* remission status. Given that this section evaluates Alcohol Use Disorder occurring before the past 12 months, by definition the specifier In Early Remission, which is for periods of remission lasting between 3 months and 12 months, cannot be applied. If the individual has been in remission for 12 months or longer (i.e., no Alcohol Use Disorder criteria met except for craving), then the In Sustained Remission specifier applies. Note that individuals with Alcohol Use Disorder before the past 12 months and who for the past 12 months have had alcohol use symptoms meeting only one of the Alcohol Use Disorder criteria would qualify for neither In Sustained Remission nor Alcohol Use Disorder in the past 12 months, and they would not qualify for any remission specifier. Such individuals would have been considered to be In Sustained Partial Remission in DSM-IV.

11.9.5 Ratings for Past-12-Month Nonalcohol Substance Use Disorders (E.10–E.18)

The drug classes have been reorganized in DSM-5 and the SCID-5. There is no longer a separate drug class for cocaine (it is included within the Stimulants grouping), and Hallucinogens and Phencyclidine (PCP) have been separated into two separate drug classes in the SCID-5 (although they are combined within DSM-5 as Hallucinogen-Related Disorders). Moreover, Inhalants, which were included within the "Other" drug class in the DSM-IV SCID, are now split from that grouping into their own drug class in the SCID-5. "Polysubstance Dependence" has been eliminated in DSM-5, and that category has been eliminated from the SCID-5 as well. Given the lower threshold for Substance Use Disorder in DSM-5, many cases that would have been diagnosed in DSM-IV as having Polysubstance Dependence (i.e., use of multiple drug classes indiscriminately, each at a level that was subthreshold for DSM-IV Substance Dependence) would qualify for a diagnosis of Substance Use Disorder for at least some of the indiscriminately used drug classes.

This SCID-5 section begins with a determination of whether the history of use during the past 12 months of each of the 10 drug classes is above the minimum needed to warrant assessment. First, the Lifetime Alcohol and Drug Use section of the Overview (pages 7–8 in the Patient Version and pages 5–6 in the Nonpatient Version) is reviewed, with a focus on the right-hand column, which contains the ratings for use during the past 12 months. The interviewer then fills out the horizontal drug class "indicator bar" (see example below), coding a "3" for each drug class that was rated "3" in the right-hand column in the

Overview Lifetime Alcohol and Drug Use section and "1" for each drug class that was rated "1" in the right-hand column.

In the example below, if the subject has acknowledged illegally buying and using alprazolam tablets several times per month for the past year but denies using any other drugs, a "3" would be coded in the right-hand column of the Sedatives-hypnotics-anxiolytics row of the Overview Lifetime Drug Use Table, and a "1" would be coded for all of the other drug classes.

Now I'd like to ask you about your use of drugs or medicines over your lifetime. IF DURING ASSESSMENT SUBJECT CATEGORICALLY DENIES LIFETIME DRUG USE, ASK THE FOLLOWING: **You mean you have never even tried marijuana?** IF SUBJECT STILL DENIES LIFETIME DRUG USE, SKIP TO SCREENING MODULE. OTHERWISE, CONTINUE WITH DRUG ASSESSMENT.	FOR EACH SPECIFIC DRUG IN THE CLASS, INDICATE USE PATTERN BASED ON QUESTIONS AT THE BOTTOM OF THE PAGE	**LIFETIME** Rate "3" if used more than 6 times in any year (other than past year) or, if prescribed/OTC, the possibility of abuse		**PAST YEAR** Rate "3" if used more than 6 times in the past year or, if prescribed/ OTC, the possibility of abuse		
Have you taken any pills to calm you down, help you relax, or help you sleep? (Drugs like Valium, Xanax, Ativan, Klonopin, Ambien, Sonata, or Lunesta?)	Sedatives-hypnotics-anxiolytics:	1	3	1	③	ONP15 ONP15a
Have you ever used marijuana ("pot," "grass," "weed"), hashish ("hash"), THC, K2, or "spice"?	Cannabis:	1	3	①	3	ONP16 ONP16a

Accordingly, the interviewer would code a "3" in the Sedatives column of the drug use indicator bar on the top of page E.10, and a "1" for all of the other drug classes (see example below).

SEDATIVE/ HYPNOTIC/ANX	CANNABIS	STIMULANTS	OPIOIDS	INHALANTS	PCP	HALLUCINOGENS	OTHER/ UNKNOWN
③	3	3	3	3	3	3	3
1	①	①	①	①	①	①	①
E39	E40	E41	E42	E43	E44	E45	E46

In order to allow maximum flexibility in the assessment of the Substance Use Disorder criteria, three options are offered that differ based on how many drug classes the interviewer wants to assess at the same time. **The first option is determining the presence of Substance Use Disorder for the single most problematic substance.** This option is most appropriate for the typical SCID user who is interested in whether or not there has ever been a diagnosis of a Substance Use Disorder (regardless of drug) and was the "standard" method used in the SCID-RV for DSM-IV. The interviewer is instructed to select the single drug class most likely associated with a diagnosis of a Substance Use Disorder in the past 12 months and assess the Substance Use Disorder criteria for only that drug class. This decision is made based on the answer to the questions "Which drug or medication caused you the most problems over the past 12 months, since (ONE YEAR AGO)? Which one did you use the most? Which was your 'drug of choice?'" In those situations in which the subject clearly has a preference for one drug class over any of the others, the choice is straightforward. However, for those subjects using multiple drug classes, deciding which single drug class to focus on can be more challenging. In such cases, the decision should be based on a combination of frequency of drug use and clinical salience. In those cases in which it seems likely that a diagnosis of Substance Use Disorder will be met for more than one drug class, the

drug class likely to be the most severe (i.e., to be associated with greatest number of Substance Use Disorder items coded "3") should be selected first.

If criteria have been met for a Substance Use Disorder in the past 12 months, the evaluation stops there (indicating the presence of a diagnosis of a Substance Use Disorder for the past 12 months). If criteria are NOT met and there is evidence of clinically significant use of one of the other drug classes, the interviewer is instructed to continue asking about those other drug classes in sequence until either criteria are met for a Substance Use Disorder in the past 12 months or there are no more drug classes left that the subject has acknowledged using at least six times in 12 months.

Consider the following example of a subject who has acknowledged using high doses of marijuana daily, going on 5-day cocaine binges sporadically, and taking Ecstasy on two occasions in the past year. Given that the subject used cannabis most heavily (and thus is the drug use pattern most likely to meet criteria for a Substance Use Disorder), cannabis was the drug class selected for initial assessment by the interviewer. However, if the interviewer had decided that it was more clinically important to assess the cocaine use given its typically more problematic nature, cocaine could have been selected first instead. The interviewer proceeds with the assessment of the 11 Criterion A Substance Use Disorder items, rewording each question to clarify that the questions apply to the subject's marijuana use. If the subject's pattern of marijuana use does not meet criteria for a Cannabis Use Disorder, the interviewer returns to page E.11 because the subject's cocaine use was significant enough to evaluate use of that drug class. If criteria were not met at the end of the evaluation of the cocaine items, the interviewer would then be finished with the evaluation of past 12-months' Substance Use Disorder because the subject's Ecstasy use was below the minimum threshold of six times in a year.

The second option is determining a Substance Use Disorder for each of the three most problematic drug classes. The three drug classes most heavily used or most problematic in the past 12 months are identified, and the 11 Criterion A Substance Use Disorder items are checked for whether each criterion was met for each drug class. This assessment can be conducted either simultaneously for each item (i.e., determining for each item whether the criterion was met for each of the three drug classes at the same time), or sequentially for each drug class (i.e., going through the full 11 items three times in sequence, one for each drug class), depending on the preference of the interviewer. While the simultaneous method is likely to be more efficient because each question for each criterion is read in its entirety only once, it requires the subject to continually jump back and forth from one class of substance to the next for the assessment of Substance Use Disorder before the past 12 months, from one past time frame to the next.

Consider, for example, a subject who has regularly used marijuana, cocaine, heroin, and mescaline over the past 12 months. With this option, the interviewer would likely choose marijuana, cocaine, and heroin for the assessment, leaving out the mescaline because it was used the least heavily of the drug classes. If the interviewer prefers using the simultaneous technique, when assessing the first item (i.e., substance taken in larger amounts or over a longer period than intended), the interviewer would ask the question as follows: "During the past year, have you found that once you started using marijuana you ended up using much more than you intended to? For example, you planned to have just a few hits but you ended up having much more. Tell me about that. How about with your cocaine use—once you started using it, did you end up taking more than you were planning to? How about with your heroin use?" If the sequential technique is used, the interviewer would first assess the 11 items for marijuana, then make a second pass through the 11 items to assess the cocaine use, and finally make a third pass through the 11 items to assess the heroin use.

The third option is the most comprehensive and is equivalent to the method used in the Alternate Substance Module in the SCID for DSM-IV. All drug classes that are at the assessment threshold (i.e.,

used at least six times in a 12-month period) are inquired about for each of the 11 Criterion A items. As was the case with the second option, this assessment can be conducted either simultaneously for each item or sequentially for each drug class.

After deciding which drug classes are to be evaluated during the past 12 months, as instructed on page E.10, the interviewer should circle the appropriate column headers containing the drug class names on each page in which the past 12-month criteria are being assessed (i.e., pages E.11 through E.18) in order to help the interviewer keep straight which drug classes are being evaluated.

Criterion A1—Larger amounts/longer periods than intended: 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 a couple of hits tonight"). Note that the breaking of these self-imposed limits (e.g., the subject ends up smoking a whole joint) must occur OFTEN in order to be coded "3." There is something of a paradox inherent in the evaluation of Criterion A1 (and Criterion A2 as well). In order to qualify for these items, the individual must have developed enough insight about having a drug problem (or wanting to avoid developing a drug problem) to want to control its use. Criterion A1 and Criterion A2 are therefore not applicable to 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 A2—Persistent desire or failed efforts to cut down/control substance use: This item is rated "3" under two circumstances. First, if the subject has had a persistent desire to stop, cut down, or control his or her drug use, presumably because of a self-awareness that it has been problematic in some way, a rating of "3" would apply. Although DSM-5 leaves the definition of "persistent" up to clinical judgment, a period in which the person's desire to cut back or control substance use that occurred for most of the time lasting for at least 1 month would be a reasonable minimum duration to count as "persistent." Second, in cases in which the subject does not have a persistent desire to cut down or control substance use but nonetheless has tried unsuccessfully to do so (e.g., in response to repeated demands from family members), a rating of "3" would also apply. Note that for an effort to cut down or control substance use to be considered "successful" and justify a rating for this item, the period of controlled or diminished use must have lasted for an extended period of time (e.g., months or years).

Criterion A3—Great deal of time spent on substance use: This three-part item covers the various ways in which drug use may become a central focus of the subject's life. This is especially variable across drug classes because of differences in cost, availability, legality, and the typical pattern of use of a 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 establish in advance specific study-wide rules (e.g., at least 4 hours per day for most days). As a rule of thumb, two evenings per week spent smoking pot is not "a great deal of time" and probably justifies a rating of "2"; whereas being high every day certainly would justify a rating of "3."

Criterion A4—Craving: This item refers to the strong urge or desire to use the substance at times when the substance is not actually being used. The intensity threshold for craving should be such that the craving has some negative impact on the person. For example, the urge to use the substance might be so strong that the subject has trouble thinking about anything else, or the urge to use might have resulted in significant discomfort or greatly weakened the subject's resolve to cut back on or quit using

the substance. In some subjects, the urge to use the substance is associated with specific cues, like seeing drug paraphernalia or running into a buddy on the street with whom the subject has used drugs. To explore this typical trigger for craving, the follow-up question asks whether the craving is associated with certain situations.

Criterion A5—Failure to fulfill obligations at work, school, and/or home, or has poor performance: A rating of "3" for this item requires specific evidence that it was the effects of the substance use (e.g., intoxication, withdrawal, or "hangover") that resulted in the subject's failure to fulfill a major role obligation on at least two occasions. The accompanying examples illustrate the wide range of the types of activities that may be affected: repeated absences from work or poor work performance; absences, suspensions, or expulsions from school; and neglect of children or household responsibilities. Note that simply being high while at work, at school, or taking care of children without impairment is not sufficient to justify a rating of "3"; there must be some evidence that the effects of the substance significantly interfered with functioning in one of these domains.

Criterion A6—Continued use despite recurrent interpersonal problems as a result of substance use: Like Criterion A5, Criterion A6 reflects social or interpersonal problems that are caused by the effects of substance use, such as marital strain caused by spousal arguments or physical fights that occur during periods of intoxication. Unlike Criterion A5, a rating of "3" requires that the subject continue to use the substance despite these problems. Criterion A6 is difficult to evaluate when the interpersonal conflict is possibly attributable to an underlying relational problem rather than to the individual's substance use. An example would be arguments about occasional nonproblematic substance use with a spouse who believes that even minimal drug use is intolerable and with whom the subject has had recurrent marital strain involving other issues.

Criterion A7—Important activities given up at work, school, or home so that time can be spent on substance use: The prototypical subject qualifying for this item is a heroin addict who has essentially given up all activities except those associated with procuring and using heroin. However, it may also be applied, for example, to an amateur athlete who has stopped sports activities because of substance use or to a person who has stopped seeing all her good friends so she can stay home and get high.

Criterion A8—Use in physically hazardous situations: 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 if the substance use caused sufficient impairment in coordination or cognition to create a physically hazardous situation (e.g., driving or hunting while high on an impairing substance). To facilitate a proper inquiry, the first question simply establishes that the subject has used the substance before engaging in an activity that requires coordination and concentration. If the subject acknowledges such use, the follow-up question then establishes whether the subject was in fact impaired to a degree that someone could have been injured as a result of the impaired coordination or concentration.

It is important to consider the type of substance and the amount used when inferring the likely level of impairment associated with the substance used, a judgment that works both ways. For example, the benefit of the doubt might be given to someone who says, for example, that he can drive perfectly well after using a "bump" of cocaine. On the other hand, if someone admits to taking a high dose of hallucinogens and insists that he or she was not impaired, the interviewer may choose to rate a "3" nonetheless.

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 act would warrant a rating of "3." The intent of Criterion A8 is to rate behavior that puts the subject or others in immediate danger because his or her coordination or cognition is impaired by the substance.

Criterion A9—Continued use despite knowledge that physical or psychological problems are caused or made worse by the substance: Like Criterion A6, 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. Therefore, in order to qualify for a rating of "3" on this item, the subject must first acknowledge understanding that the physical or psychological problems that he or she is experiencing are caused by use of the substance, and that despite this knowledge, he or she has been unable to stop using it or cut down significantly. Examples of physical problems include serious damage to nasal mucosa from sniffing cocaine or exacerbation of asthma from smoking excessive amounts of marijuana. Examples of psychological problems are cocaine-induced paranoia, or panic attacks precipitated by marijuana.

Criterion A10—Tolerance: Tolerance is the need for a person to use greater amounts of a substance to get the same effect as when that person first started using it. Although Criterion A10 requires the need for "markedly increased amounts," how much the amount needs to have increased is left up to clinical judgment. (The DSM-III-R version of the tolerance criterion specified at least a 50% increase, but this requirement was dropped from DSM-IV because it was felt to be pseudoprecise.) Tolerance develops most frequently with amphetamines, cocaine, opioids, and sedatives (especially barbiturates). Tolerance for many drugs (e.g., cocaine, barbiturates, heroin) is usually apparent to the subject. It may not be possible to establish tolerance for drugs like marijuana, where the quality of the drug varies markedly.

Criterion A11—Withdrawal: *Withdrawal* is indicated by the development of the characteristic substance-specific withdrawal syndrome (page E.28) 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 stimulants and cannabis. DSM-5 does not provide criteria sets for withdrawal from hallucinogens, PCP, or inhalants.

Rating for Past-12-Month Substance Use Disorders: The assessment of Past-12-Month Substance Use Disorder concludes with an evaluation for each drug class as to whether or not criteria have been met in the past 12 months. A rating of "3" is given if at least two items have been coded "3" during the past 12 months, and a rating of "1" is given if less than two criteria have been coded "3" for the past 12 months. For each drug class rated "3," the interviewer follows the line to the severity rating box and rates the severity of the Substance Use Disorder (Mild if 2–3 items have been present during the past 12 months; Moderate if 4–5 items have been present; and Severe if 6 or more items have been present). The interviewer then continues with the ratings in the middle of page E.17, in which the name of the specific substance within the general drug class is recorded (e.g., Adderall [dextroamphetamine/amphetamine] would be listed if that was the specific stimulant that the subject used in the past 12 months that led to a diagnosis of a Stimulant Use Disorder).

For any drug class rated as not being present in the past 12 months (i.e., rated "1"), the interviewer follows the line down from the rating of "1" to the instruction that indicates the subsequent flow through the SCID-5, which depends on which option is being used to guide the assessment in this

section. If the interviewer is following Option #1 (most problematic substance), the instruction asks the interviewer to consider whether there has been evidence of clinically significant use of a drug class other than the one that was just assessed for which criteria were not met. If so, the interviewer will need to return to the top of page E.11 and go through the Substance Use Disorder items again, but this time focusing on this other drug class, given that the use pattern for the first drug class that was assessed was not severe enough to meet criteria. If and only if there are no other drug classes for which there is the possibility of a Past-12-Month Substance Use Disorder should the interviewer then skip out and continue with the assessment of the Substance Use Disorder criteria for the period before the past 12 months. If the interviewer is following Option #2 (top three drug classes) or Option #3 (all drug classes at assessment threshold) and if none of the drug classes that were evaluated warranted a diagnosis of a Past-12-Month Substance Use Disorder, then the interviewer continues with the evaluation of Substance Use Disorder for the period before the past 12 months.

Chronology for Past-12-Month Substance Use Disorders: The evaluation of Past-12-Month Substance Use Disorder concludes with a chronology section that serves to indicate whether or not the Substance Use Disorder should be considered current, which for reasons discussed in Section 11.9.2, "Ratings for Past-12-Month Alcohol Use Chronology," is defined as any Substance Use Disorder criterion being met in the past 3 months (except for craving, which does not count). For each drug class rated "3" (i.e., with at least one Criterion A item present in the past 3 months), the interviewer should follow the line down directly to the age-at-onset box and then enter the age at onset of the Substance Use Disorder for that particular drug class. For each drug class that was evaluated for the past 12 months but for which a rating of "1" was given (i.e., there have not been any items present in the past 3 months), the interviewer follows the line down from the "1" rating and then rates the remission status as In Early Remission. Sustained Remission, which requires that no items (except for craving) have been present for the past 12 months, is not an option because there must have been at least two items present during the past 12 months for the interviewer to have entered the chronology section. Following the line further down for that drug class, the interviewer then indicates whether or not the subject is currently in a controlled environment (i.e., an environment where access to substances is restricted), the number of months that have elapsed since the subject last had any Substance Use Disorder symptoms, and then finally the age at onset. Although having a rating for In a Controlled Environment for each drug class is technically unnecessary (because it is independent of drug class), such a rating has been included for each drug class to ensure that it is coded; consequently, these ratings share the same field code. Note that the opioid drug class has an additional box to allow the interviewer to indicate whether or not the subject is currently on maintenance therapy.

11.9.6 Ratings for Prior-to-Past-12-Month Nonalcohol Substance Use Disorders (E.19–E.26)

For drug classes for which the subject has acknowledged lifetime use but for which criteria are not met for a Substance Use Disorder in the past 12 months, the interviewer then needs to decide whether or not to evaluate for a history of a Substance Use Disorder occurring before the period of the past 12 months or to skip to the next module.

This section begins with a determination of whether the history of use during the lifetime period before the last 12 months of each of the 10 drug classes is above the minimum to warrant assessment. The Lifetime Alcohol and Drug Use section of the Overview (pages 7–8 in the Patient Version and pages 5–6 in the Nonpatient Version) should be reviewed, focusing on the center column, which contains the ratings for use during the period before the past 12 months. The interviewer then fills out the horizontal "drug class indicator bar," coding "3" for each drug class that was rated "3" in the center column of the

Overview Lifetime Alcohol and Drug Use section and "1" for each drug class that was rated "1" in the center column. As noted in the instruction on the top of page E.19, under the typical administration of the SCID-5, this review of drug classes should NOT be done for drug classes for which criteria are met for a Substance Use Disorder in the past 12 months (as determined on pages E.11–E.17). However, interviewers interested in assessing whether the severity of Substance Use Disorder prior to the past 12 months is more severe than Substance Use Disorder over the past 12 months (see discussion for Alcohol Use Disorder before the past 12 months in Section 11.9.3, "Ratings for Prior-to-Past-12-Month Alcohol Use Disorder") should ignore the instruction to code "3" only for drug classes for which criteria are not already currently met and instead should code "3" for each drug class based on the coding in the middle column for all drug classes. This allows for the evaluation of Substance Use Disorder before the past 12 months regardless of whether criteria were met in the past 12 months.

The next step is to determine which drug classes should be evaluated for the period before the past 12 months on pages E.20–E.26 and, for each selected drug class, which 12-month time frame in the past to focus on. Whichever option was used for Past-12-Month Substance Use Disorder on pages E.11–E.17 should be used here as well. After deciding which drug classes are to be evaluated during the lifetime period before the past 12 months (as instructed on page E.19), the interviewer should circle the appropriate column headers containing the drug class names on each page in which the criteria for the lifetime period before the past 12 months are being assessed (i.e., pages E.20–E.26), in order to help keep track of which drug classes are being evaluated.

A 12-month time frame must also be selected for each drug class for which to evaluate the clustering of 11 Criterion A Substance Use Disorder items (akin to the 2-week time frame that is needed to determine the clustering of items for past MDE). This time frame should be selected with the goal of maximizing the likelihood of meeting criteria for Substance Use Disorder for that drug class and should be based on when in the person's life he or she has been using that substance the most and when use of that substance caused the most problems (which should be known to the interviewer based on the answers to these questions provided during the review of lifetime drug use in the Overview on pages 7–8 in the Patient Version, or pages 5–6 in the Nonpatient Version). Thus, on the top of page E.20, for each drug class the interviewer inquires "Looking back over your life, if you had to pick a 12-month period when you were using [CIRCLED DRUG CLASS] the most or during which your use of [CIRCLED DRUG CLASS] caused you the most problems, when would that be?" The start of the selected time frame (in terms of month and year) is then recorded immediately below the question on page E.20.

When assessing each of the 11 Criterion A Substance Use Disorder items, both the name of the drug class and the relevant time frame need to be inserted into the actual wording of the question. For Options #2 and #3 in which multiple drug classes are being assessed, the names of the drug classes and their corresponding time frames should be included. Consider, for example, a subject who used marijuana most heavily during a 12-month time frame starting in January 2005, had serious problems with cocaine during a 12-month time frame starting in December 1999, and took heroin daily during a 12-month time frame also starting in December 1999. When assessing the first Substance Use Disorder Criterion A item (i.e., substance taken in larger amounts or over a longer period than intended), the interviewer would ask the question as follows: "During the 12-month period starting in January 2005 during which you used marijuana heavily, did you find that once you started using marijuana you ended up using much more than you intended to? For example, you planned to have just a few hits but you ended up having much more. Tell me about that. How about during the 12-month period starting in December 1999 during which you used a lot of cocaine? Once you started using it, did you end up taking more than you were planning to? How about during the same time when you were using heroin every day?"

Ratings for Prior-to-Past-12-Month Substance Use Disorder (page E.26): After finishing the ratings for the 11 Criterion A Substance Use Disorder items for each selected drug class, the interviewer counts up the number of items to see if there are at least 2 items present during the 12-month time frame selected for that drug class. For each drug class coded "3" (i.e., criteria for Substance Use Disorder before the past 12 months have been met), the interviewer should follow the line to the next box, which requires determination of the year during which the criteria were last met. The interviewer then indicates the severity of the Substance Use Disorder based on the number of symptoms coded "3" during the same 12-month period. Finally, the interviewer follows the line down to the box where age at onset is recorded. Note that the opioid drug class has an additional box to allow the interviewer to indicate whether or not the subject is currently on maintenance therapy.

For any evaluated drug class for which a Substance Use Disorder was not present in the period before the past 12 months (i.e., rated "1"), the interviewer follows the line down from the rating of "1" to the instruction that indicates the subsequent flow through the SCID-5, which depends on which option is being used to guide the assessment in this section. If the interviewer is following Option #1 (most problematic substance), the interviewer considers whether there has been evidence of clinically significant use of another drug class before the past 12 months (other than those already assessed). If so, the interviewer will need to return to the top of page E.20 and go through the Substance Use Disorder items again, but this time focusing on this other drug class, given that the use pattern for the first drug class assessed was not severe enough to meet criteria. If and only if there are no other drug classes for which there is the possibility of a Substance Use Disorder diagnosis before the past 12 months should the interviewer then skip out and go to the next module. If the interviewer is following Option #2 (top three drug classes) or Option #3 (all drug classes at assessment threshold) and if any of the drug classes that were evaluated warranted a diagnosis of a Substance Use Disorder before the past 12 months, then the interviewer continues on page E.27 to record the name of the specific substance and remission status.

The interviewer next records the name of the specific substance within the general drug class (e.g., heroin would be listed if that was the specific opioid that the subject used during the period before the past 12 months that led to a diagnosis of a Substance Use Disorder). Finally, the interviewer indicates whether the subject is In a Controlled Environment (i.e., if the individual is currently in an environment where access to substances is restricted) and the subject's remission status. Given that this section evaluates Substance Use Disorder occurring before the past 12 months, then by definition the specifier In Early Remission, which is for periods of remission lasting 3–12 months, cannot be applied. If the individual has been in remission for 12 months or longer (i.e., with no Substance Use Disorder criteria for that drug class met except for craving), then the In Sustained Remission specifier applies. Note that individuals with Substance Use Disorder before the past 12 months—and who for the past 12 months have had substance use symptoms meeting only one of the Substance Use Disorder criteria—would qualify for neither In Sustained Remission nor Substance Use Disorder in the past 12 months, and thus would not qualify for any remission specifier. Such individuals would have been diagnosed as In Sustained Partial Remission in DSM-IV.

11.10 Module F. Anxiety Disorders

The core version of Module F assesses lifetime Panic Disorder, Agoraphobia, Social Anxiety Disorder, Specific Phobia (with questions added for each of these disorders to determine if criteria are also met currently), current and past Generalized Anxiety Disorder, Other Specified Anxiety Disorder, Anxiety Disorder Due to Another Medical Condition, and Substance/Medication-Induced Anxiety Disorder. For an enhanced Module F, there is an optional assessment for current Separation Anxiety Disorder, which is inserted into the SCID-5 flow between Generalized Anxiety Disorder and Other Specified Anxiety Disorder. (See Section 5, "Steps for Customizing the SCID-5-RV for Your Study," in this User's Guide for an explanation of how to construct the SCID with optional components.)

Note that in keeping with the reorganization of disorders in DSM-5, OCD is now included in Module G (Obsessive-Compulsive and Related Disorders), and PTSD is now included in Module L (Trauma- and Stressor-Related Disorders); thus, these disorders are no longer included with Anxiety Disorders in Module F.

Module F marks the beginning of the use of answers to the Screening Module questions. From this point on in the SCID-5 (with the exception of Module L), the interviewer should refer back to the Screening Module answers when deciding how to begin the assessment of each disorder. The assessment of each disorder begins with a bracketed section that provides the interviewer with several choices depending on how the corresponding screening question was answered during the Overview (for an example, see Figure 2 in Section 11.3, "Screening Module," in this User's Guide). The first bracketed choice always indicates the point in the SCID to which the interviewer should skip in case of a negative answer on the Screening Module. Thus, if the corresponding question in the Screening Module was answered "NO" and the interviewer has no reason to think that the subject may have misunderstood the question or is purposely minimizing his or her reporting, then the assessment of the disorder can be skipped. If the subject answered "YES" to the screening question, the interviewer picks the next (middle) choice in the brackets and essentially paraphrases the original screening question (e.g., "You've said that you have been very anxious or afraid of situations like going out of the house alone, being in crowds, going to stores, standing in lines, or traveling on buses or trains") in order to verify that the initial "YES" answer was correct. The interviewer then proceeds to ask the provided follow-up questions for the initial item. If the interviewer either did not administer the Screening Module at the beginning of the SCID-5 or decides to recheck the answer to the Screening Module question (e.g., because of an equivocal answer or the emergence of additional information that contradicts the original answer), the interviewer picks the third bracketed option and repeats the Screening Module question (e.g., "Have you ever been very anxious about or afraid of situations like going out of the house alone, being in crowds, going to stores, standing in lines, or traveling on buses or trains?").

11.10.1 Ratings for Panic Disorder (F.1–F.6)

The assessment of Panic Disorder begins by assessing the lifetime presence of panic attacks in order to accommodate the inclusion of the specifier With Panic Attacks (which theoretically can be applied to any DSM-5 disorder). In cases where there have not been at least two recurrent unexpected panic attacks (which qualifies for Panic Disorder), the interviewer notes the context in which the panic attacks have occurred (e.g., during separation from attachment figures) so that the With Panic Attack specifier can be indicated later in the SCID when the corresponding disorder is diagnosed (e.g., Separation Anxiety Disorder With Panic Attacks).

Criteria for panic attack: The term "panic attack" is often incorrectly used by subjects to describe any escalating anxiety. A true panic attack is characterized by a sudden and intense rush of physical manifestations of anxiety combined with cognitions such as a fear of dying or losing control. Immediately after establishing the characteristic crescendo of anxiety and before going through the individual symptoms, the interviewer asks the subject to provide a description of the last bad panic attack that he or she has experienced. This serves several functions. First, it provides an opportunity for the subject to describe the attack and its accompanying symptoms in his or her own words before being cued with the list of 13 panic attack symptoms. Second, it allows the interviewer to more easily determine whether the course of the reported anxiety episode is consistent with a true panic attack (i.e., an abrupt surge of intense fear that reaches a peak within minutes), rather than a more extended period of anxiety that might be more consistent with Generalized Anxiety Disorder. Finally, the determination of whether at least four symptoms occurred together during the same panic attack is facilitated by asking the subject to think about a *specific* attack when answering the questions about the individual symptoms. One potential pitfall of this approach is that if the threshold of four symptoms is not reached, it may be because the panic attack chosen by the subject was not the most severe one that the person has experienced. Thus, in cases in which the four-symptom threshold is not reached, the interviewer needs to ask if there have been any more severe panic attacks in terms of the number of symptoms. If so, the interviewer will need to apply the list of symptoms to this more severe panic attack to determine if the four-symptom threshold is met for that attack.

Criterion A—Recurrent unexpected panic attacks: The presence of a panic attack is not necessarily indicative of Panic Disorder because panic attacks can occur in the context of a number of other disorders. For example, if a person with a snake phobia goes on a hike and has a panic attack after encountering 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." Thus, the initial question explicitly asks whether the panic attack occurred "out of the blue" (i.e., in a situation in which the subject would not have expected to be nervous or anxious, like sitting at home watching TV). If the subject answers "YES," this is confirmed by asking the subject to describe the context in which the attack occurred. However, it is not uncommon for individuals with Panic Disorder to fairly quickly (and mistakenly) assume that there is a cause-and-effect relationship between the situations in which the attacks have developed and the attacks themselves, and thus deny that any of the attacks have occurred out of the blue. Therefore, there are explicit follow-up questions about the context of the initial panic attacks in order to determine if at least two of them at some time in the subject's life were unexpected.

For some individuals, panic attacks may 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 this concept refers to the absence of a clear association between an environmental stimulus and the occurrence of a panic attack. Common sense (we hope) will lead the interviewer to exclude as unexpected those 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. If none (or only one) of the attacks have been unexpected, the interviewer is instructed to skip to page F.7 to determine whether the attacks occurred in the context of another mental disorder. This information is used for coding the With Panic Attacks specifier, which has been added to the end of many of the disorders in the SCID-5.

Criterion B—Worry about having another attack and/or maladaptive change in behavior: This criterion ensures that the panic attacks have had a negative impact on the person's life, which can be manifested in either of two ways. The subject may experience persistent concern or worry (lasting at least 1 month) about having additional attacks or about "their consequences," which has been interpreted in the

SCID-5 to mean that the subject is worried about those symptoms that represent consequences of the attack, such as having a heart attack, losing control, or "going crazy." Alternatively, the subject may start avoiding places or situations that he or she believes might trigger a panic attack or else might make escape difficult in the event of having a panic attack. 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 fear of having an attack in a place that's not "safe" (possibly Agoraphobia).

Criterion C—Not due to a GMC and not substance/medication-induced: This criterion instructs the interviewer to consider and rule out a GMC or a substance/medication as an etiological cause of the panic attacks, in which case Anxiety Disorder Due to Another Medical Condition or Substance/ Medication-Induced Anxiety Disorder is diagnosed. Remember to carefully assess caffeine intake, and remember that caffeine is present in a variety of foods, beverages, and over-the-counter medications like headache remedies. Although substance use may be associated with the initial onset of panic attacks, a substance-induced etiology should be considered when subsequent panic attacks occur ONLY in the context of substance use. See Section 10, "Differentiating General Medical and Substance/Medication Etiologies From Primary Disorders," in this User's Guide for a general discussion of how to apply this criterion, as well as how to assess the criteria for Anxiety Disorder Due to Another Medical Condition and Substance/Medication-Induced Anxiety Disorder.

Criterion D—Not better explained by another mental disorder: This criterion covers essentially the same diagnostic ground as the requirement that there be at least two panic attacks that are unexpected. It asks 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 long-standing Social Anxiety Disorder who has a panic attack while speaking in front of a large group of people. Because the panic attack was triggered by exposure to an anxiety-provoking situation (i.e., speaking in public), it is considered to be better explained by the diagnosis of Social Anxiety Disorder. In such cases the interviewer may want to note the presence of the panic attacks by indicating the With Panic Attacks specifier for the Social Anxiety Disorder diagnosis.

Ratings for Panic Disorder Chronology: The assessment of the Panic Disorder criteria up to this point has focused on lifetime Panic Disorder. The Panic Disorder Chronology section serves to determine whether criteria are currently met for Panic Disorder (i.e., in the past month) and, if not, how long it has been since the subject last had a symptom of Panic Disorder (i.e., either a panic attack or maladaptive behavior). Rather than repeating the assessment of each Panic Disorder criterion for the current month, the SCID-5 only requires a determination of whether or not there have been at least two panic attacks in the past month—or whether during the past month there has been either worry about having another panic attack (Criterion B1) or maladaptive changes in behavior related to the attacks (Criterion B2). Note that when assessing the presence of *current* panic attacks, it is not required that those occurring in the past month be unexpected; the DSM-5 diagnosis of Panic Disorder requires only that at least two panic attacks during the individual's *lifetime* were unexpected. For the purposes of determining whether the Panic Disorder is current, recurrent panic attacks cued by places or situations would count, reflecting the typical course of Panic Disorder in which panic attacks subsequent to the initial unexpected panic attacks become associated with environmental triggers.

Ratings for Expected Panic Attacks: Note that these ratings are made only if the interviewer has skipped out of Criterion A for Panic Disorder (i.e., the panic attacks do not qualify as recurrent and unexpected). The With Panic Attacks specifier is applicable to panic attacks that occur in the context of an Anxiety Disorder or other mental disorder. Although the DSM-5 text and criteria do not prohibit the application

of this specifier to those other disorders if criteria are also met for lifetime Panic Disorder, once it is established that an individual has Panic Disorder, it is likely that all panic attacks experienced by the individual would be best explained as part of the Panic Disorder. Consequently, the SCID-5 only allows the use of the With Panic Attacks specifier if criteria have never been met for Panic Disorder.

For subjects without Panic Disorder who have experienced panic attacks that occur in the context of another mental disorder, the ratings on page F.7 allow the interviewer to note the various diagnostic contexts in which the panic attacks have occurred. When applying the With Panic Attacks specifier, which appears as the final specifier for many of the disorders throughout the SCID-5, the interviewer should refer back to page F.7 to note the diagnostic context in which the panic attacks have occurred. For example, if the subject has experienced panic attacks occurring in the context of a Specific Phobia (e.g., triggered by exposure to the phobic stimulus), this would be noted on page F.7 by checking "phobic situations" (field code F34). When later in the SCID-5 the interviewer considers the With Panic Attacks specifier on page F.22 at the conclusion of the assessment of Specific Phobia, the interviewer should refer back to page F.7 to confirm that there have been panic attacks occurring in the context of a phobic stimulus before indicating the presence of the With Panic Attacks specifier.

11.10.2 Ratings for Agoraphobia (F.8–F.13)

Agoraphobia is an Anxiety Disorder characterized by fear and avoidance of multiple types of places or situations because of a fear of having panic-like symptoms and fear that escape would be difficult or help unavailable. In contrast to DSM-IV, in which Agoraphobia was explicitly linked to Panic Disorder, in DSM-5 Agoraphobia is diagnosed separately from Panic Disorder, so both diagnoses are possible.

Criterion A—Fear or anxiety about at least two out of five types of situations: The first criterion for Agoraphobia in DSM-5 requires fear or anxiety about two (or more) from a list of five specific situations. The initial question from the Screening Module asks whether the subject has ever been "very anxious about or afraid of situations like going out of the house alone, being in crowds, going to stores, standing in lines, or traveling on buses or trains"—which is followed by an open-ended inquiry into the actual types of situations that the subject has feared. These questions are followed by five specific questions asking about the five types of situations specified in Criterion A (i.e., using public transportation, being in open spaces, being in enclosed spaces, standing in line or being in a crowd, being outside of the home alone). Note that each question is preceded by the conditional instruction "IF UNKNOWN," because most of the time the answers to these specific questions will already be known after the screening question and the open-ended follow-up question.

Criterion B—Fear or avoidance of situations results from thoughts that escape might be difficult or help might not be available: The assessment of this criterion involves determining the reason that the subject is afraid of or avoiding the situations in Criterion A. The first question is open-ended and asks why the subject is avoiding the situations and/or what it is that the subject is afraid would happen if he or she were in one of those situations. Follow-up questions specifically cover the most common experiences, including being afraid that it would be hard to get out of the situation in case of having a panic attack, developing a symptom that would be embarrassing, becoming impaired in some way, or being worried that there would be nobody there to help if one of these incapacitating or embarrassing symptoms suddenly developed.

Criterion C—The agoraphobic situations almost always provoke anxiety or fear: This criterion reflects the phobic nature of the disturbance, requiring relative consistency with regard to the subject's reaction when in a feared situation. Thus, an individual who becomes anxious only occasionally in an agoraphobic

situation (e.g., becomes anxious when standing in line on only one out of every five occasions) would not be diagnosed as having Agoraphobia. However, the degree of fear or anxiety expressed may vary—from anticipatory anxiety to a full panic attack, across different occasions of being in or anticipating being in a feared situation—because of various contextual factors such as the presence of a trusted companion.

Criterion D—The agoraphobic situations are actively avoided, require the presence of a companion, or are endured with intense fear or anxiety: 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 feared situations, but only with either marked distress or an accompanying companion.

Criterion E—The fear or anxiety is out of proportion to the actual threat posed by the agoraphobic situations and the sociocultural context: This criterion requires the interviewer to take into account contextual or cultural factors that might indicate that the fear, anxiety, or avoidance is normal given the context. For example, it would not make sense to diagnose Agoraphobia in an individual whose avoidance of going outside at night is a reasonable reaction to the danger of living in an extremely dangerous neighborhood. The SCID addresses this component of the criterion directly by having the interviewer ask the subject whether he or she feels any danger or threat to his or her safety when in the feared situations. Avoidance behavior based on cultural factors (e.g., prohibitions against women traveling alone in certain Muslim countries) also would not count toward the diagnosis. There is no all-purpose question to cover all such scenarios; the interviewer should ad lib questions for this criterion as appropriate, based on the cultural context of the subject.

Criterion F—The fear, anxiety, or avoidance is persistent: A minimum duration of 6 months is required to rule out transient responses.

Criterion G—The fear, anxiety, or avoidance causes clinically significant distress or impairment: Throughout the SCID-5, as here, this item is assessed by asking an open-ended question to determine the impact that the fear, anxiety, or avoidance behavior has had on the subject's life. The follow-up questions are optional and specifically cover various domains of functioning that might be impacted by the fear, anxiety, or avoidance. These questions should be asked only if it is not clear from the subject's answer whether the symptoms interfere with functioning.

Criterion H—If a GMC is present, related fear, anxiety, or avoidance is excessive: A number of GMCs, such as inflammatory bowel disease, Parkinson's disease, and severe coronary artery disease, are characterized by symptoms that at times can be physically incapacitating. Individuals with such medical conditions may appropriately avoid places or situations in which help might not be available in case of developing an incapacitating symptom related to one of these medical conditions, and in such cases a diagnosis of Agoraphobia should not be made. However, if the subject's fear, anxiety, or avoidance is clearly excessive, then the diagnosis is allowed. For example, avoiding driving for several weeks following a severe heart attack would certainly not warrant a diagnosis of Agoraphobia, whereas being housebound for 2 years following a mild heart attack might warrant the diagnosis.

Criterion I—Not better explained by another mental disorder: This criterion is similar to Criterion D in Panic Disorder and serves as a reminder 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 Anxiety Disorder. Agoraphobia involves avoidance of at least two different types 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 usually related

to the onset of panic attacks, whereas a Specific Phobia tends to be either lifelong or develop after a traumatic experience. Determining whether avoidance of social situations is related to Social Anxiety Disorder or to fear of developing a panic attack in a social situation (which could warrant a diagnosis of Agoraphobia) generally depends on the temporal relationship between the onset of panic attacks and the social avoidance. If an individual develops avoidance of social situations only AFTER the onset of panic attacks, then Agoraphobia is likely the most appropriate diagnosis. An individual with long-standing social avoidance who newly develops panic attacks when in social situations would better be considered to have Social Anxiety Disorder. Note that this criterion does NOT preclude making a diagnosis of BOTH 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).

Ratings for Agoraphobia Chronology: Assessment of the Agoraphobia criteria up to this point has focused on lifetime Agoraphobia. The Agoraphobia Chronology section serves to determine whether criteria are currently met for Agoraphobia (i.e., for the past 6 months) and, if not, how long it has been since the subject last had a symptom of Agoraphobia. Rather than repeating the assessment of each Agoraphobia criterion for the past 6 months, the SCID-5 only requires a determination of the following: whether or not there has been fear of or anxiety about at least two situations in the past 6 months (Criterion A); whether the situations are actively avoided, require the presence of a companion, or are endured with intense anxiety during the past 6 months (Criterion D); and whether the fear, anxiety, or avoidance has caused clinically significant impairment or distress in the past 6 months (Criterion G). Note that it is often not necessary to ask the subject additional questions about symptoms during the past 6 months if such information is already known from the lifetime assessment.

11.10.3 Ratings for Social Anxiety Disorder (Social Phobia) (F.14–F.18)

Two separate screening questions are provided in the Screening Module for Social Anxiety Disorder in order to cover anxiety focused on social situations (e.g., meeting new people, going on a date, going to a party), as well as performance anxiety (e.g., speaking, writing, or eating in public; using a public bathroom). A "YES" answer to either question should lead to a full evaluation of the criteria for Social Anxiety Disorder.

Criterion A—Marked fear or anxiety about one or more social situations: A wide range of social triggers may qualify for the "social situations" in this criterion—what they all have in common is that the person is exposed to the scrutiny of others. Three types of situations are included: social interactions, such as having a conversation or meeting unfamiliar people (covered by the first of the screening questions); being observed by others, such as while eating, drinking, or going to the bathroom; or performing in front of others, such as giving a speech or a musical performance. Note that in order to rate Criterion A "3," the degree of fear or anxiety must be "marked" (according to the DSM-5 criterion) or "intense" (according to the DSM-5 text, p. 203). Because concerns about public speaking are so ubiquitous, it is important that this alone does not warrant a "3" rating for Criterion A, unless it is clear that the concerns are excessive and do not diminish with practice.

Criterion B—Fear of acting in a way that will be negatively evaluated: This item establishes the reason for the fear of social situations. After starting out with an open-ended question ("What were you afraid would happen when…"), several follow-up questions covering specific reasons for the fear are offered if the subject's response to the initial question is unclear (e.g., "Were you afraid of being embarrassed because of what you might say or how you might act? Were you afraid that this would lead to your being rejected by other people? How about making others uncomfortable or offending them because of

what you said or how you acted?"). This last example applies especially to subjects from cultures with strong collectivistic orientations (e.g., Japan). Avoidance of a behavior because of concerns that the subject's own high standards will not be met (as in Obsessive-Compulsive Personality Disorder) would not warrant a rating of "3."

Criterion C—The social situations almost always provoke anxiety or fear: 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 D—Social situations are avoided or endured with intense fear or anxiety: This criterion demonstrates that avoidance of social situations is not a required part of this disorder. A diagnosis of Social Anxiety Disorder 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—The fear or anxiety is out of proportion to the actual threat posed by the social situations and to the sociocultural context: This criterion takes into account contextual or cultural factors that might indicate that the social anxiety is normal given the context. For example, it would not be appropriate to diagnose Social Anxiety Disorder in an individual whose avoidance of social situations is limited to those in which he or she is being bullied or threatened. Similarly, the diagnosis would not apply if a subject's performance anxiety were limited to situations in which a poor performance has serious negative consequences (e.g., high levels of fear and anxiety in anticipation of defending his or her thesis). Accordingly, the SCID-5 includes an open-ended question for asking the subject about his or her opinion of the likely impact of performing badly in the feared situation. The subject's answer would then be assessed to evaluate possible distortions on the part of the subject about the likelihood of performing badly (e.g., ignoring the fact that the subject has extensively rehearsed) or possible exaggeration about the impact of failing. Avoidance behavior based on cultural factors (e.g., cultural expectations that women be reticent in social situations) also would not count toward the diagnosis, but there is no all-purpose question to cover all such scenarios. The interviewer should apply ad lib questions as appropriate based on the cultural context of the subject.

Criterion F—The fear, anxiety, or avoidance is persistent: A minimum duration of 6 months is required to rule out transient responses.

Criterion G—The fear, anxiety, or avoidance causes clinically significant distress or impairment.
Throughout the SCID, as here, clinical significance is assessed by asking an open-ended question to determine the impact that the fear, anxiety, or avoidance behavior has had on the subject's life. The follow-up questions are optional and specifically cover various domains of functioning that might be impacted by the fear, anxiety, or avoidance. These questions should be asked only if it is not clear from the subject's answer whether the symptoms interfere with functioning.

Most potential diagnoses of Social Anxiety Disorder sink or swim on this clinical significance criterion. Master SCIDers may choose to skip directly to the rating of this criterion if it seems likely that the social anxiety is going to turn out to be clinically insignificant. A diagnosis of Social Anxiety Disorder 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 there is marked distress ABOUT having the fear or avoidance). Thus, for example, a fear of public speaking in a plumber who is almost never called upon to address groups of people is unlikely to meet this criterion. Some individuals who seriously constrict their lives to avoid social situations may report a lack of distress because their social anxiety is

so rarely activated. A rating of "3" may still be justified if the interviewer makes a clinical judgment that the social anxiety has had a significant negative impact on their functioning.

Criterion H—Not due to a GMC and not substance/medication-induced: The type of anxiety or avoidance seen in Social Anxiety Disorder would rarely be associated with a substance/medication or a GMC. It is possible, however, to imagine a scenario in which the individual who uses excessive amounts of caffeine or amphetamine to enhance cognitive performance in social situations has anxiety in such situations that is due to the substance use rather than the social situation itself. See Section 10, "Differentiating General Medical and Substance/Medication Etiologies From Primary Disorders," in this User's Guide for a general discussion of how to apply this criterion, as well as how to assess the criteria for Anxiety Disorder Due to Another Medical Condition and Substance/Medication-Induced Anxiety Disorder.

Criterion I—Not better explained by another mental disorder: This criterion is similar to Agoraphobia Criterion I, in that it serves as a reminder to consider whether the fear and avoidance may be better characterized as part of another mental disorder. One of the more difficult boundaries is with Agoraphobia. Typically, Agoraphobia involves avoidance of a cluster of situations, reflecting the general unpredictability of panic attacks. Determining whether avoidance of social situations is related to Social Anxiety Disorder or to fear of developing a panic attack in a social situation (which might 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 most likely the appropriate diagnosis. An individual with long-standing social avoidance who develops panic attacks when in social situations would better be considered to have Social Anxiety Disorder. Other anxiety disorders are differentiated from Social Anxiety Disorder by virtue of the focus of the anxiety (e.g., in Separation Anxiety Disorder, the anxiety is related to being separated from attachment figures, rather than being triggered by social situations).

Criterion J—If potentially embarrassing GMC or mental disorder is present, related fear, anxiety, or avoidance is unrelated or excessive: A number of GMCs (e.g., Parkinson's disease, obesity, psoriasis, disfigurement from burns or injuries) and mental disorders (e.g., Tic Disorders, Childhood-Onset Fluency Disorder [previously known as Stuttering], and Anorexia Nervosa) are characterized by symptoms that are embarrassing and could potentially lead to social ostracism. It may thus be reasonable for some subjects with such medical conditions or mental disorders to avoid social situations because of the real possibility that they will be embarrassed or rejected; such subjects should not diagnosed as having Social Anxiety Disorder. The interviewer, however, can still make a diagnosis of Social Anxiety Disorder if, according to the interviewer's judgment, either the fear or anxiety of social situations is clearly unrelated to their medical condition or mental disorder or is excessive. Note that the bracketed phrase "or potentially embarrassing mental disorder," which is not in the DSM-5 criterion, has been added to the SCID-5. The corresponding DSM-IV criterion ("If a general medical condition or other mental disorder is present, the fear…is unrelated to it, e.g., the fear is not of stuttering, trembling [in Parkinson's disease] or exhibiting abnormal eating behavior [in Anorexia Nervosa or Bulimia Nervosa]") included both GMCs and mental disorders. After discussion with the DSM-5 Anxiety Disorders Work Group, it was determined that the mental disorder component was unintentionally omitted from Criterion J.

Ratings for Social Anxiety Disorder Chronology: The assessment of the Social Anxiety Disorder criteria up to this point has focused on lifetime Social Anxiety Disorder. The Social Anxiety Disorder Chronology section serves to determine whether criteria are currently met for Social Anxiety Disorder (i.e., for the past 6 months) and, if not, how long it has been since the subject last had a symptom of Social Anxiety Disorder. Rather than repeating the assessment of each Social Anxiety Disorder criterion for the past

6 months, the SCID only requires a determination of whether or not there has been marked fear or anxiety about one or more social situations (Criterion A); whether the situations are avoided or endured with intense fear or anxiety (Criterion D); and whether the fear, anxiety, or avoidance is causing clinically significant impairment or distress in the past 6 months (Criterion G). Note that it is often not necessary to ask the subject additional questions about symptoms during the past 6 months if such information is already known from the lifetime assessment.

SPECIFIERS FOR SOCIAL ANXIETY DISORDER
PERFORMANCE ONLY: This specifier is given if the social situations that the individual is afraid of are restricted to speaking or performing in public.

WITH PANIC ATTACKS: This specifier should be considered if there has been a history of panic attacks (pages F.1–F.2), criteria for Panic Disorder have never been met (pages F.2–F.5), panic attacks have occurred in the context of social situations (page F.7), and there has been at least one panic attack during the past month. Note that a 1-month time frame has been added to the SCID-5 as a way of operationalizing this specifier; no time frame or frequency requirement is included in DSM-5.

11.10.4 Ratings for Specific Phobia (F.19–F.23)

Criterion A—Marked fear or anxiety about a specific object or situation: Note that in order to rate this criterion "3," the degree of fear or anxiety must be marked.

Criterion B—The social situations almost always provoke immediate fear or anxiety: Similar to the corresponding criterion in Social Anxiety Disorder, this criterion requires that the fear response occur consistently across repeated exposures to the phobic stimulus. Note, however, that it adds the requirement that the fear reaction be immediate.

Criterion C—Phobic situations are actively avoided or endured with intense fear or anxiety: This criterion differs from the corresponding criterion in Social Anxiety Disorder by explicitly requiring active avoidance. According to DSM-5, *active avoidance* means that the individual intentionally behaves in ways that are designed to prevent or minimize contact with phobic objects or situations (e.g., taking tunnels instead of bridges on a daily commute to work because of a fear of heights). Thus, the SCID question asks whether the subject has gone out of his or her way to avoid the phobic stimulus.

Criterion D—The fear or anxiety is out of proportion to the actual danger posed by the specific object or situation and to the sociocultural context: The SCID question queries the subject regarding his or her opinion about the actual danger posed by the phobic stimulus ("How dangerous would you say it actually is to [BE EXPOSED TO PHOBIC STIMULUS]?"). Given that individuals with Specific Phobia tend to overestimate the actual danger posed by the phobic stimulus, the determination of whether the fear is disproportionate should be based on the clinical judgment of the interviewer and not the subject. Moreover, this criterion requires the interviewer to take into account contextual or cultural factors that might indicate that the fear or avoidance is normal given the context. For example, it would not make sense to diagnose a Specific Phobia in an individual whose fear of the dark is reasonable in the context of ongoing risk of violence.

Criterion E—The fear, anxiety, or avoidance is persistent: A minimum duration of 6 months is required to rule out transient responses.

Criterion F—The fear, anxiety, or avoidance causes clinically significant distress or impairment:
Throughout the SCID, as here, clinical significance is assessed by asking an open-ended question to determine the impact that the fear, anxiety, or avoidance behavior has had on the subject's life. The additional follow-up questions are optional and specifically cover various domains of functioning that might be impacted by the fear, anxiety, or avoidance. These questions should be asked only if it is not clear from the subject's answer whether the symptoms interfere with functioning.

When a subject describes anxieties that he or she had as a child, and the interviewer is uncertain whether there was enough impairment or distress at that time to warrant a past diagnosis of a phobia, this additional guideline may be helpful: make the diagnosis if the condition was sufficiently persistent and impairing to the point 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.

Most potential diagnoses of a Specific Phobia sink or swim on this criterion. Master SCIDers 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. A diagnosis of 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 there is marked distress ABOUT having the phobia). Thus, for example, a snake phobia in someone who lives in New York City is unlikely to meet the criterion.

Criterion G—Not better explained by another mental disorder: Specific Phobia is, in a sense, residual to other disorders with stimulus-triggered anxiety, because most of them are described in specific categories. For example, although fear or avoidance of contamination may meet the criteria for a "dirt phobia," if the fear or avoidance occurs as part of a contamination obsession and hand-washing compulsion in OCD, 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 or avoidance are unrelated to the other disorder. For example, a subject with Agoraphobia may avoid many different situations or activities because of the fear of having a panic attack, but the subject may also have specific phobias that are unrelated to the Agoraphobia. It is up to the interviewer to get enough information to judge whether, in addition to Agoraphobia, there are fears unrelated to Agoraphobia (e.g., of dogs, spiders).

Ratings for Specific Phobia Chronology: The assessment of the Specific Phobia criteria up to this point has focused on lifetime Specific Phobia. The Specific Phobia Chronology section serves to determine whether criteria are currently met for Specific Phobia (i.e., for the past 6 months) and, if not, how long it has been since the subject last had a symptom of Specific Phobia. Rather than repeating the assessment of each Specific Phobia criterion for the past 6 months, the SCID only requires a determination of whether or not there has been marked fear or anxiety about a specific object or situation (Criterion A); whether the phobic situations are avoided or endured with intense fear or anxiety (Criterion C); and whether the fear, anxiety, or avoidance is causing clinically significant impairment or distress in the past 6 months (Criterion F). Note that it is often not necessary to ask the subject additional questions about symptoms during the past 6 months if such information is already known from the lifetime assessment.

SPECIFIERS FOR SPECIFIC PHOBIA
TYPES OF SPECIFIC PHOBIA: The interviewer should specify the current Specific Phobia "type" based on whether the phobic stimulus involves animals, the natural environment, blood-injection-injury,

situational phobias (such as airplanes, elevators, or closed spaces), or "other." Given that multiple Specific Phobias are possible, the interviewer should check off as many as apply.

WITH PANIC ATTACKS: This specifier should be considered if there has been a history of panic attacks (pages F.1–F.2), criteria for Panic Disorder have never been met (pages F.4–F.5), panic attacks have occurred only in the context of exposure to a phobic stimulus (page F.7), and there has been at least one panic attack during the past month. Note that a 1-month time frame has been added to the SCID-5 as a way of operationalizing this specifier; no time frame or frequency requirement is included in DSM-5.

11.10.5 Ratings for Current and Past Generalized Anxiety Disorder (F.24–F.30)

As was the case with Persistent Depressive Disorder, criteria for current (past 6 months) Generalized Anxiety Disorder (GAD) are assessed first. Past GAD is assessed only if criteria are not met for current GAD or if the screening question for current GAD is answered "NO" (i.e., "Over the last several months, have you been feeling anxious and worried for a lot of the time?") and the screening question for past GAD is answered "YES."

Criterion A—Excessive anxiety and worry about a variety of events and activities, more days than not: Separate questions are provided for each of the three subcomponents of this criterion that *all* must be true in order for the criterion to be rated "3." First, the anxiety and worry are not focused on one or two issues, but instead involve a wide range of issues. For example, an individual worries about the health and safety of his spouse and children, his financial situation, the possibility of being late for an appointment, not having enough time to finish a project, what to wear to a party, whether his job is in jeopardy, and whether there are jellyfish in the water. Second, the anxiety and worry must be "excessive"—that is, the intensity, duration, or frequency of the anxiety and worry is out of proportion to the actual likelihood or impact of the anticipated event (e.g., an individual is preoccupied with worries about a 30-year-old spouse dying of a heart attack despite the absence of any medical problems aside from mild cholesterol elevation). Finally, the anxiety and worry must have occurred for more days than not during the past 6 months.

Criterion B—Worry is difficult to control: Recognizing that the worry is excessive, subjects with this problem will often tell themselves to stop worrying and will try to think about something else, but will find themselves drifting inexorably back to whatever worry is preoccupying them at the time.

Criterion C—Three of six associated symptoms: Note that like the generalized anxiety itself, some of these symptoms must also be present "more days than not" for a period of at least 6 months.

Criterion D—Causes clinically significant distress or impairment: This criterion helps to set the boundary between the clinically significant anxiety in GAD and "normal" anxiety. The anxiety and worry should be considered clinically significant only if they are sufficiently severe to cause marked distress or impairment in functioning.

Criterion E—Not due to a GMC and not substance/medication-induced: GMCs and substances/ medications must be considered and ruled out as etiological factors for the anxiety, in which case Anxiety Disorder Due to Another Medical Condition or Substance/Medication-Induced Anxiety Disorder is diagnosed. Remember to carefully assess caffeine intake, bearing in mind that caffeine is present in a variety of foods, beverages, and over-the-counter medications like headache remedies. See Section 10, "Differentiating General Medical and Substance/Medication Etiologies From Primary Disorders," in this

User's Guide for a general discussion of how to apply this criterion, as well as how to assess the criteria for Anxiety Disorder Due to Another Medical Condition and Substance/Medication-Induced Anxiety Disorder.

Criterion F—Not better explained by another mental disorder: Anxiety and worry are important components of many mental disorders. A diagnosis of GAD is appropriate only if there are additional symptoms of anxiety and foci of worry that are not part of this other disorder. For example, an individual with prominent social anxiety who is preoccupied by worry about being embarrassed in social situations might warrant an additional diagnosis of GAD if there are also worries about health, finances, and other nonsocial issues.

SPECIFIER FOR GENERALIZED ANXIETY DISORDER

WITH PANIC ATTACKS: This specifier should be considered if there has been a history of panic attacks (pages F.1–F.2), criteria for Panic Disorder have never been met (pages F.4–F.5), panic attacks have occurred in the context of generalized anxiety and worry (page F.7), and there has been at least one panic attack during the past month. Note that a 1-month time frame has been added to the SCID-5 as a way of operationalizing this specifier; no time frame or frequency requirement is specified in DSM-5.

A number of the skip instructions included in the assessment of past GAD direct the interviewer to "GO TO ***OTHER SPECIFIED ANXIETY DISORDER*** F. 31 ***OR*** ***SEPARATION ANXIETY DISORDER,** * Opt-F.1" The inclusion of the "OR" here indicates that the implementation of this instruction depends on whether or not the optional assessment of Separation Anxiety Disorder is intended. If Separation Anxiety Disorder is supposed to be included as part of the SCID-5- evaluation, then the interviewer continues with the evaluation of Separation Anxiety Disorder on page Opt-F.1, which should have been inserted between pages F.30 and F.31 (see Section 5, "Steps for Customizing the SCID-5-RV for Your Study," in this User's Guide for instructions on how to configure the SCID-5 to include optional disorders). Otherwise, the interviewer skips to the evaluation of Other Specified Anxiety Disorder.

11.10.6 Ratings for Current Separation Anxiety Disorder (Optional; Opt-F.1–Opt-F.4)

Separation Anxiety Disorder is characterized by excessive fear or anxiety of being separated from those to whom the individual is attached, coupled with avoidance of that separation. Separation Anxiety Disorder is not part of the core SCID-5. If an assessment of Separation Anxiety Disorder is needed, pages Opt-F.1 through Opt-F.4 should be inserted between pages F.30 (the last page of Past GAD) and F.31 (the first page of Other Specified Anxiety Disorder). Furthermore, only current Separation Anxiety Disorder is assessed (i.e., during the past 6 months).

The screening question for Separation Anxiety Disorder departs from the standard SCID practice of tying the screening question to the initial criterion of the screened disorder (e.g., the question "Over the last several months, have you been feeling anxious and worried for a lot of the time?" screens for GAD Criterion A). This approach only works for monothetic criteria sets in which a negative rating for the initial criterion rules out the whole disorder. Because Separation Anxiety Disorder starts with a polythetic criterion (i.e., at least three out of a list of eight separation anxiety items are required so that there is no one item whose absence rules out the disorder), the screening question covers the entire disorder—i.e., "In the past 6 months, since (SIX MONTHS AGO), have you been especially anxious about being separated from people you're attached to (like your parents, children, or partner)?" If this screening question is answered "NO," the interviewer skips to the evaluation of Other Specified Anxiety Disorder.

The evaluation starts out by following up the screening question with an assessment of who the subject is most anxious about being separated from. The interviewer should then substitute this attachment figure in place of the phrase "MAJOR ATTACHMENT FIGURE" when asking the subsequent questions evaluating the criteria for Separation Anxiety Disorder. For example, if the subject indicated that he was most anxious about being separated from his wife, then the first question would be asked as follows: "In the past 6 months, since (SIX MONTHS AGO), have you gotten upset when you've thought about being separated from your wife or being away from home?"

Criterion A—Developmentally inappropriate and excessive fear or anxiety concerning separation: For each of the following eight items in Criterion A, the interviewer must determine that the fear or anxiety is both developmentally inappropriate and excessive. The challenge in evaluating separation anxiety in adults is to determine whether the fear is "excessive," because the requirement that the fear or anxiety be "developmentally inappropriate" is relevant only to the evaluation of young children in whom such fears may in fact be developmentally appropriate. Some distress occurring upon separation from loved ones is within the range of normal. These criteria should only be rated "3" if the degree and duration of distress is clearly "excessive" given the circumstances. For example, developing a certain amount of parental anxiety in anticipation of an only child leaving home to go to college is normal; experiencing fear and anxiety every morning when the child leaves to attend a local school is clearly excessive. Similarly, a subject being anxious about his or her spouse dying would be normal if that spouse were admitted to the hospital for open heart surgery; daily severe anxiety about the spouse dying when the spouse is in perfectly good health would qualify for a rating of "3."

> *Criterion A4—Persistent reluctance or refusal to go out, away from home, to school, to work, or elsewhere because of fear of separation*: Two questions are provided for this item to cover both a focus on generally not wanting to leave home and a focus on not wanting to go to work, school, or elsewhere. In both cases, the follow-up question verifies that the reason for the refusal is the fear of being separated from attachment figures or being away from home.
>
> *Criterion A5—Persistent and excessive fear or reluctance about being alone or without major attachment figures at home or in other settings*: This criterion covers two scenarios in which anxiety about being alone or not being in the presence of an attachment figure may occur. Some individuals get very anxious when they are at home alone or not in the presence of the attachment figure. Other individuals develop anxiety in situations when they are outside the home with the attachment figure (e.g., going to a shopping mall) and become separated from the attachment figure (e.g., the attachment figure walks into a store without the subject knowing which store it is).

Criterion B—The fear, anxiety, or avoidance is persistent: In most cases, the 6-month duration will already have been established given the 6-month time frame that was targeted in both the screening question and in questions covering Criterion A items.

Criterion C—The disturbance causes clinically significant distress or impairment: Throughout the SCID-5, as here, clinical significance is assessed by asking an open-ended question to determine the impact that symptoms of separation anxiety have had on the subject's life. The additional follow-up questions are optional and specifically cover various domains of functioning that might be impacted by the separation anxiety symptoms. These questions should be asked only if it is not clear from the subject's answer whether the symptoms interfere with functioning.

Most potential diagnoses of Separation Anxiety Disorder sink or swim on this criterion. Master SCIDers may choose to skip directly to the rating of this criterion if it seems likely that the separation anxiety is not clinically significant.

Criterion D—Not better explained by another mental disorder: This criterion is similar to Criterion I in Agoraphobia, in that it reminds the interviewer to consider whether the symptoms may be better considered as part of another mental disorder that is also characterized by anxiety and avoidance. For example, like those with Separation Anxiety Disorder, some individuals with Autism Spectrum Disorder may refuse to leave home. However, in Autism Spectrum Disorder, the refusal to leave home is a manifestation of the characteristic, excessive resistance to change—and not to concerns about separation from attachment figures as in Separation Anxiety Disorder.

SPECIFIER FOR SEPARATION ANXIETY DISORDER

WITH PANIC ATTACKS: This specifier should be considered if there has been a history of panic attacks (pages F.1–F.2), criteria for Panic Disorder have never been met (page F.5), panic attacks have occurred in the context of anxiety about separation from attachment figures (page F.8), and there has been at least one panic attack during the past month. Note that a 1-month time frame has been added to the SCID-5 as a way of operationalizing this specifier; no time frame or frequency requirement is included in DSM-5.

11.10.7 Ratings for Other Specified Anxiety Disorder (F.31–F.32)

Other Specified Anxiety Disorder should be considered if there are symptoms characteristic of an Anxiety Disorder that do not meet criteria for Panic Disorder, Agoraphobia, Social Anxiety Disorder, Specific Phobia, Generalized Anxiety Disorder, Separation Anxiety Disorder, or Adjustment Disorder With Anxiety or Adjustment Disorder With Mixed Anxiety and Depressed Mood. The paragraph defining Other Specified Anxiety Disorder in DSM-5 (p. 233) has been converted into a set of four ratings in the SCID-5, as discussed below.

Symptoms characteristic of an Anxiety Disorder: This category is for presentations that include symptoms of anxiety, worry, fear, or fear-associated avoidance that do not meet the full criteria for Panic Disorder, Agoraphobia, Social Anxiety Disorder, Specific Phobia, Generalized Anxiety Disorder (all diagnosed in Module F), Separation Anxiety Disorder (optionally diagnosed in Module F), or Adjustment Disorder With Anxiety or Adjustment Disorder With Mixed Anxiety and Depressed Mood (both diagnosed in Module L). Note that the clause excluding Adjustment Disorder With Anxiety and Adjustment Disorder With Mixed Anxiety and Depressed Mood was mistakenly left out of DSM-5 and has been restored here in the SCID-5. Given that Adjustment Disorder has not yet been diagnosed at this point in the SCID, the interviewer may need to return here and revise this rating if criteria are later met for Adjustment Disorder With Anxiety or Adjustment Disorder With Mixed Anxiety and Depressed Mood.

Symptoms cause clinically significant distress or impairment: This item clarifies that all of the DSM-5 Other Specified categories must meet the basic requirement that the symptoms be sufficiently severe as to have a negative impact on the subject's life.

Not due to a GMC and not substance/medication-induced: This item instructs the interviewer to consider and rule out a GMC or a substance/medication as an etiological factor for the anxiety symptoms, in which case an Anxiety Disorder Due to Another Medical Condition or Substance/Medication-Induced Anxiety Disorder is diagnosed. Note that the descriptions of Other Specified (and Unspecified) Anxiety

Disorders in DSM-5 do not specifically require that general medical or substance/medication etiologies be ruled out. The requirement to rule out such etiologies has been added to the SCID-5-RV to ensure that subthreshold presentations due to a GMC or substance/medication get properly diagnosed. See Section 10, "Differentiating General Medical and Substance/Medication Etiologies From Primary Disorders," in this User's Guide for a general discussion of how to apply this criterion, as well as how to assess the criteria for Anxiety Disorder Due to Another Medical Condition and Substance/Medication-Induced Anxiety Disorder.

Indication of the type of symptomatic presentation: The first two examples in DSM-5 of presentations that can be given the "other specified" designation (supplemented by four additional SCID-specific examples) are included. (The two examples of culture-related syndromes have not been included.) For anxiety presentations not covered by one of these examples, the "other" designation should be used, in which case the specific reason that the criteria for one of the Anxiety Disorders were not met should be recorded. For presentations in which there is insufficient information to make a more specific diagnosis, Unspecified Type should be recorded.

11.11 Module G. Obsessive-Compulsive and Related Disorders

Module G assesses current and lifetime Obsessive-Compulsive Disorder (OCD), and three diagnoses new to DSM-5 and the SCID-5: Other Specified Obsessive-Compulsive and Related Disorder, Obsessive-Compulsive and Related Disorder Due to Another Medical Condition, and Substance/Medication-Induced Obsessive-Compulsive and Related Disorder. Four optional disorders are also included: Hoarding Disorder, Body Dysmorphic Disorder, Trichotillomania (Hair-Pulling Disorder), and Excoriation (Skin-Picking) Disorder.

11.11.1 Ratings for Obsessive-Compulsive Disorder (G.1–G7)

The assessment of OCD begins with four separate screening questions: three (on page G.1) that are designed to screen for the various types of obsessions experienced by individuals with OCD and one (on page G.2) to screen for compulsions. The first question screens for **obsessive thoughts** ("Have you ever been bothered by thoughts that kept coming back to you even when you didn't want them to, like being exposed to germs or dirt or needing everything to be lined up in a certain way?"). The second question screens for **obsessive images** ("How about having images pop into your head that you didn't want, like violent or horrible scenes or something of a sexual nature?"). The final question screens for **obsessive urges** ("How about having urges to do something that kept coming back to you even though you didn't want them to, like an urge to harm a loved one?"). As noted in the instruction on the top of the page, because some individuals with OCD may be reluctant to confide their obsessions to the interviewer so early in the interview, if all three questions were answered "NO" in the Screening Module, the interviewer should consider repeating the screening questions if there is any suggestion that obsessions might have been present (e.g., if the subject initially gave an equivocal answer). The placement of the screening question for compulsions is unique in the SCID-5 in that it is tied to a criterion that is on the second page of the assessment of the disorder, rather than the top of the first page.

Criterion A: Obsessions (1)—recurrent or persistent thoughts, images, or urges: Obsessions are defined as thoughts, images, or urges that are experienced, at some time during the disturbance, as intrusive and unwanted. A subject's experience of these thoughts, images, and urges may change over the course of the disturbance; hence, the inclusion of the phrase "at some time during the disturbance." 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. An example of an obsession is the subject's recurrent, intrusive, and anxiety-provoking thought while driving that he or she ran over a small child without realizing it. Spending an equal amount of time worrying about 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 in which the differential diagnosis is particularly challenging, it may be useful to consider the fact that obsessions and compulsions usually go together (more than 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 deciding point may be whether or not compulsions are also present.

Although the follow-up question asks whether the thoughts, images, or urges made the person upset, this aspect of the criterion (causing marked anxiety or distress) is not actually a requirement given that the criterion specifies that this is true "for most individuals." Hence, the fact that the thoughts, images, or urges do not cause anxiety or distress does *not* rule out the diagnosis of an obsession—rather, the presence of anxiety or distress will strengthen confidence in the fact that this is an obsession rather than another kind of repetitive thought.

Criterion A: Obsessions (2)—attempts to ignore, neutralize, or suppress: Another distinguishing feature of an obsession is that the individual tries to reduce the anxiety or distress associated with the thought, image, or urge by actively trying to ignore or suppress the thought (e.g., by avoiding known triggers, such as dirt in an individual with a contamination obsession) or by attempting to neutralize the thought by performing a compulsion.

Criterion A: Compulsions (1) and (2)—repetitive behaviors or mental acts: Compulsions are distinguished from other forms of repetitive behavior by the underlying motivation for the behavior: to reduce or prevent anxiety associated with an obsession. For example, hand washing alleviates the anxiety triggered by an obsession of being 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 anxiety accompanying an obsession is very helpful in differentiating a compulsion from other repetitive behaviors, such as tics and stereotypies. The most common compulsions are behaviors like hand washing, repetitive touching, or picking up and replacing an object repeatedly—or mental acts such as counting or repeating a word or phrase over and over.

The questions corresponding to the second half of the criterion ("How many times would you do [COMPULSIVE ACT]? Are you doing [COMPULSIVE ACT] more than really makes sense?") are intended to help the interviewer determine whether the "behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive," which is a required feature in addition to the requirement that the behaviors or mental acts are aimed at preventing or reducing distress. Even though the subject is asked whether he or she thinks the behavior "really makes sense," the judgment about whether the behaviors or acts are connected in a realistic way or are excessive is ultimately up to the interviewer.

Skip instruction if no obsessions or compulsions: The interviewer moves on to the evaluation of Criterion B only if Criterion A is present. Thus, if there have never been any obsessions or compulsions, determined either by screening out of all three questions for obsessions and the one question for compulsions or by evaluating the separate criteria for obsessions or compulsions, then the interviewer can skip out either to Other Specified Obsessive-Compulsive and Related Disorder (page G.8) or to the optional assessment of Hoarding Disorder (page Opt-G.1), depending on whether the interviewer will be assessing the optional disorders for this module.

Criterion B—Clinical significance: This criterion requires that the obsessions or compulsions be clinically significant. Note that the standard DSM-5 clinical significance criterion also includes a phrase allowing this criterion to be met if the obsessions or compulsions are "time-consuming (e.g., take more than 1 hour per day)." This clause allows the interviewer to conclude that impairment is present even in the face of the subject's apparent lack of concern or denial about the behavior or the rationalization that it is useful.

Criterion C—Not due to a GMC and not substance/medication-induced: This item instructs the interviewer to consider and rule out a GMC or a substance/medication as an etiological factor for the obsessions or compulsions, in which case Obsessive-Compulsive and Related Disorder Due to Another Medical Condition or Substance/Medication-Induced Obsessive-Compulsive and Related Disorder is diagnosed. (Such etiologies are quite rare.) See Section 10, "Differentiating General Medical and Substance/Medication Etiologies From Primary Disorders," in this User's Guide for a general discussion of how to apply this criterion, as well as how to assess the criteria for Obsessive-Compulsive and Related Disorder Due to Another Medical Condition and Substance/Medication-Induced Obsessive-Compulsive and Related Disorder.

Criterion D–Not better explained by another mental disorder: 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. Many of the symptoms of other disorders that are given in DSM-5 do not really meet the test of "intrusive and unwanted." For example, when a subject 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, but not that it is intrusive or unwanted. Of course, Anorexia Nervosa does not protect someone against OCD; the subject with Anorexia Nervosa may also have hand washing rituals that are unrelated to her eating disorder, and therefore be given both diagnoses.

Ratings for OCD Chronology: The assessment of the OCD criteria up to this point has focused on lifetime OCD. The OCD Chronology section serves to determine whether criteria are currently met for OCD (i.e., in the past month) and, if not, how long it has been since the subject last had a symptom of OCD (i.e., either an obsession or a compulsion). Rather than repeating the assessment of each OCD criterion for the current month, the SCID-5 only requires a determination of whether or not there have been any obsessions or compulsions in the past month (Criterion A) and whether in the past month the obsessions or compulsions have been time-consuming or have caused marked distress or impairment in functioning (Criterion B).

SPECIFIERS FOR OBSESSIVE-COMPULSIVE DISORDER

CURRENT LEVEL OF INSIGHT: Many individuals with OCD have dysfunctional beliefs, such as believing that having a forbidden thought is as bad as acting on it. Given that individuals with OCD vary in the degree of insight they have about the accuracy of the beliefs that underlie their obsessive-compulsive symptoms, DSM-5 offers specifiers for the current level of insight, which has been operationalized in the SCID-5 as the average level of insight over the past week.

When applying this specifier, it is therefore necessary to pick one belief from among the many dysfunctional beliefs that the subject with OCD might have. Thus, the SCID-5 starts out by asking the subject which belief that something terrible will happen is the most upsetting to him or her. Once that has been established, the interviewer then asks the subject "on average, over the past week, how strongly did you believe this terrible thing was going to happen?" Individuals for whom the specifier With Good or Fair Insight (rating of "1") applies understand that their OCD beliefs are definitely or probably not true or that they may or may not be true (e.g., the individual believes that the house definitely will not, probably will not, or may or may not burn down if the stove is not checked 30 times). Individuals for whom the specifier With Poor Insight (rating of "2") applies think that their OCD beliefs are probably true (e.g., the individual believes that the house will probably burn down if the stove is not checked 30 times). Individuals for whom the specifier With Absent Insight/Delusional Beliefs (rating of "3") applies are completely convinced that their OCD beliefs are true (e.g., the individual is convinced that the house will burn down if the stove is not checked 30 times). For those cases of OCD in which

OCD symptoms are not associated with a feared consequence that involves a belief, a rating of "4" (not applicable) is given.

TIC-RELATED: This specifier is to indicate a current or past history of a Tic Disorder.

WITH PANIC ATTACKS: This specifier should be considered if there has been a history of panic attacks (pages F.1–F.2), criteria for Panic Disorder have never been met (pages F.2–F.5), panic attacks have occurred in the context of anxiety about obsessions or compulsions (page F.7), and there has been at least one panic attack during the past month. Note that a 1-month time frame has been added to the SCID-5 as a way of operationalizing this specifier; no time frame or frequency requirement is included in DSM-5.

11.11.2 Ratings for Hoarding Disorder (Optional; Opt-G.1–Opt-G.5)

Hoarding Disorder is not part of the core SCID-5. If an assessment of Hoarding Disorder is needed, pages Opt-G.1 through Opt-G.5 should be inserted between pages G.7 (the last page of OCD) and G.8 (the first page of Other Specified Obsessive-Compulsive and Related Disorder).

Criterion A—Persistent difficulty discarding or parting with possessions, regardless of their actual value: In order to establish that the difficulty is "persistent," the interviewer asks the subject "how long has this been going on?" Although the term "persistent" is not precisely defined, according to DSM-5 it is intended to indicate a long-standing difficulty rather than more transient life circumstances that may lead to excessive clutter, such as inheriting property. The difficulty discarding possessions refers to any form of discarding, including throwing away, selling, giving away, or recycling. According to the DSM-5 text (p. 248)—

> The most commonly saved items are newspapers, magazines, old clothing, bags, books, mail, and paperwork, but virtually any item can be saved. The nature of items is not limited to possessions that most other people would define as useless or of limited value. Many individuals collect and save large numbers of valuable things as well, which are often found in piles mixed with other less valuable items.

Criterion B—This difficulty is due to a perceived need to save the items and to distress associated with discarding them: The first part of this criterion focuses on establishing that the person purposefully saves things, as opposed to the passive accumulation of possessions that can occur in other disorders such as Major Depressive Disorder or Schizophrenia. Typically, the main reasons the person gives for these difficulties are the perceived utility or aesthetic value of the items or strong sentimental attachment to the possessions. Some individuals feel responsible for the fate of their possessions and often go to great lengths to avoid being wasteful. Fears of losing important information are also common. The second part of this criterion highlights the fact that individuals with Hoarding Disorder experience distress when possessions are removed, either by themselves or other people.

Criterion C—Results in the accumulation of possessions that congest and clutter active living areas and compromise intended use: This criterion establishes that accumulation of items is so severe that intended use of active living areas is no longer possible. Examples from the DSM-5 text include the individual not being able to cook in the kitchen, sleep in his or her bed, or sit in a chair because of the clutter. The DSM-5 text defines *clutter* as "a large group of usually unrelated or marginally related objects piled together in a disorganized fashion in spaces designed for other purposes (e.g., tabletops, floor, hallway)" (p. 248). This criterion also emphasizes the "active" living areas of the home, rather than more peripheral areas such as garages, attics, or basements, which are sometimes cluttered in homes of

individuals without Hoarding Disorder. In some cases, however, living areas may be uncluttered because of the intervention of third parties (e.g., family members, cleaners, local authorities). Thus, the SCID follows up a negative answer to the first question with "Is that only because family members or other people got rid of your stuff?"

Hoarding Disorder should be contrasted with normative collecting behavior, which is organized and systematic, even if in some cases the actual amount of possessions may be similar to the amount accumulated by an individual with Hoarding Disorder. Normative collecting does not produce the clutter typical of Hoarding Disorder.

Criterion D—The hoarding causes clinically significant distress or impairment: Throughout the SCID-5, as here, clinical significance is assessed by asking an open-ended question to determine the impact that hoarding symptoms have had on the subject's life. The additional follow-up questions are optional and specifically cover various domains of functioning that might be impacted by the hoarding symptoms. These questions should be asked only if it is not clear from the subject's answer whether the symptoms interfere with functioning. Note that a number of hoarding-specific questions have been added—e.g., "Has your living area been so filled with stuff that it was unsafe for yourself or others living with you? (Like being a fire hazard, or having a serious problem with mold, rats, or insects?)."

Criterion E—Not due to a GMC: This item instructs the interviewer to consider and rule out a GMC as an etiological factor for the obsessions or compulsions, in which case Obsessive-Compulsive and Related Disorder Due to Another Medical Condition is diagnosed. Note that in contrast to similar criteria throughout the SCID-5, the version for Hoarding Disorder does not include an exclusion for substance/medication-induced etiologies, because substances/medications are not known to cause hoarding behavior. See Section 10.1, "Assessing Disorders Due to a General Medical Condition," in this User's Guide for a general discussion of how to apply this criterion, as well as how to assess the criteria for Obsessive-Compulsive and Related Disorder Due to Another Medical Condition.

Criterion F—Not better explained by another mental disorder: Hoarding symptoms, particularly the accumulation of items, can occur in the context of other mental disorders (e.g., as a consequence of not throwing things out related to decreased energy in Major Depressive Disorder). Hoarding Disorder should not be diagnosed under such circumstances.

Ratings for Hoarding Disorder Chronology: The assessment of the Hoarding Disorder criteria up to this point has focused on lifetime Hoarding Disorder. The Hoarding Disorder Chronology section serves to determine whether criteria are currently met for Hoarding Disorder (i.e., in the past month) and, if not, how long it has been since the subject last had any symptom of Hoarding Disorder. Rather than repeating the assessment of each Hoarding Disorder criterion for the current month, the SCID-5 only requires a determination of whether or not there has been persistent difficulty throwing things out (Criterion A), whether it has resulted in the accumulation of possessions to the extent that it compromises the use of active living areas (Criterion C), and whether it is causing clinically significant distress or impairment (Criterion D).

SPECIFIERS FOR HOARDING DISORDER

WITH EXCESSIVE ACQUISITION: This specifier applies if difficulty discarding items is accompanied by behaviors such as excessive buying, acquisition of free items (e.g., leaflets, items discarded by others), and stealing. Whether acquisition of items should be considered "excessive" is a clinical judgment that

should take into account whether or not the acquired items are needed and whether or not there is available space to store them.

CURRENT LEVEL OF INSIGHT: This specifier indicates the extent to which the person appreciates the problematic nature of his or her hoarding-related beliefs and behaviors (pertaining to difficulty discarding items, clutter, or excessive acquisition). Given that such insight can fluctuate over time, it is intended to apply to the average level of insight that the person has had about the problematic nature of his beliefs or behaviors over the prior week. Individuals for whom the specifier With Good or Fair Insight (rating of "1") applies recognize that their hoarding beliefs or behaviors are problematic; individuals for whom the specifier With Poor Insight (rating of "2") applies are mostly convinced that their hoarding beliefs or behaviors are not problematic despite evidence to the contrary; and individuals for whom the specifier With Absent Insight/Delusional Beliefs (rating of "3") applies are completely convinced that their hoarding beliefs or behaviors are not problematic despite evidence to the contrary.

WITH PANIC ATTACKS: This specifier should be considered if there has been a history of panic attacks (pages F.1–F.2), criteria for Panic Disorder have never been met (pages F.4–F.5), panic attacks have occurred in the context of hoarding (page F.7), and there has been at least one panic attack during the past month. Note that a 1-month time frame has been added to the SCID-5 as a way of operationalizing this specifier; no time frame or frequency requirement is included in DSM-5.

11.11.3 Ratings for Body Dysmorphic Disorder (Optional; Opt-G.6–Opt-G.9)

Body Dysmorphic Disorder (BDD) is not part of the core SCID-5. If an assessment of BDD is needed, insert pages Opt-G.6 through Opt-G.9 between pages G.7 (the last page of OCD) and G.8 (the first page of Other Specified Obsessive-Compulsive and Related Disorder), usually after the pages for Optional Hoarding Disorder (Opt-G.1–Opt-G.5) if that is being assessed.

Criterion A—Preoccupation with one or more perceived defects or flaws in physical appearance: The perceived defects or flaws in physical appearance are not observable or appear slight to others. There are three components of this criterion that must be established by the interviewer in order to justify a rating of "3": 1) the presence of a belief that an aspect of the subject's physical appearance is flawed or defective; 2) the fact that the perceived flaw in physical appearance is either not observable or only appears slight to others; and 3) the fact that the person is preoccupied by such beliefs. Only the first component is covered by the screening question ("Have you been very concerned that there was something wrong with your physical appearance or the way one or more parts of your body looks?"). The second component is best determined by the interviewer actually seeing the supposedly defective body part so that he or she can judge whether it is either not observable at all or only slight. However, the subject might be either too ashamed of the appearance of that body part to show it to the interviewer or else it may be in a location that is not easily accessible or too private to be shown. In such cases, the interviewer will have to make a clinical judgment based on the subject's description of the supposed defect and the answers to questions such as "Have other people noticed it? What have they said?" Finally, whether or not the subject is preoccupied is assessed by asking the subject two questions. The first simply inquires about the amount of time the subject has thought about the defect; clinical judgment needs to be applied to determine whether that amount of time would qualify as "preoccupied." The second question asks the subject directly whether he or she has thought about it more than he or she should have, which would also qualify as "preoccupied."

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).

Criterion B—Repetitive behaviors or mental acts in responsive to the appearance concerns:
Manifestations of Criterion B can take the form of mental acts, such as the subject comparing the way his or her body part looks compared to that of others; and repetitive behaviors, such as the subject repeatedly checking in mirrors to see how body parts look, spending a lot of time trying to fix the defect or cover it up (e.g., with makeup, clothing, hairstyle, pulling out hair or picking skin, seeking consultations with plastic surgeons, excessive exercise or weight lifting), or the subject seeking reassurance from others about the body part. Note that performing these mental acts or behaviors only needs to have happened "at some point during the course of the disorder."

Criterion C—The preoccupation causes clinically significant distress or impairment: As is done throughout the SCID-5 when assessing clinical significance, the interviewer starts by asking an open-ended question to determine the impact that the preoccupation with having a perceived defect has had on the subject's life. The additional follow-up questions are optional and specifically cover various domains of functioning that might be impacted by the preoccupation with appearance. These questions should be asked only if it is not clear from the subject's answers whether the symptoms interfere with functioning. Note that some BDD-specific questions have been added (e.g., "Have you avoided intimate relationships because of [BDD SXS]?").

Criterion D—Not better explained by an Eating Disorder: Most individuals with Eating Disorders are dissatisfied with their appearance, focusing on body fat and weight. In such individuals, a diagnosis of BDD should only be considered if there are preoccupations with aspects of body appearance other than body fat or weight. That said, a diagnosis of BDD can be made for individuals whose concern about appearance is centered on body fat as long as they do not also have an Eating Disorder.

Ratings for BDD Chronology: The assessment of the BDD criteria up to this point has focused on lifetime BDD. The BDD Chronology section serves to determine whether criteria are currently met for BDD (i.e., in the past month) and, if not, how long it has been since the subject last had any symptom of BDD. Rather than repeating the assessment of each BDD criterion for the current month, the SCID-5 only requires a determination of whether or not there has been preoccupation with perceived defects in appearance in the past month (Criterion A) and whether it is causing clinically significant distress or impairment (Criterion C).

SPECIFIERS FOR BODY DYSMORPHIC DISORDER
CURRENT LEVEL OF INSIGHT: This specifier indicates the extent to which the person is convinced that their BDD beliefs (e.g., "I look deformed") are true. Given that such insight can fluctuate over time, it is intended to apply to the average level of insight that the person has had about the BDD beliefs over the prior week. Individuals for whom the specifier With Good or Fair Insight (rating of "1") applies recognize that their BDD beliefs are definitely or probably not true or that they may or may not be true; individuals for whom the specifier With Poor Insight (rating of "2") applies think that the BDD beliefs are probably true; and individuals for whom the specifier With Absent Insight/Delusional Beliefs (rating of "3") applies are completely convinced that their BDD beliefs are true.

WITH MUSCLE DYSMORPHIA: The individual is preoccupied with the idea that his or her body build is too small or insufficiently muscular. This specifier is used even if the individual is preoccupied with other body areas, which is often the case.

WITH PANIC ATTACKS: This specifier should be considered if there has been a history of panic attacks (pages F.1–F.2), criteria for Panic Disorder have never been met (pages F.2–F.5), panic attacks have occurred in the context of the preoccupation with defects in appearance (page F.7), and there has been at least one panic attack during the past month. Note that a 1-month time frame has been added to the SCID-5 as a way of operationalizing this specifier; no time frame or frequency requirement is included in DSM-5.

11.11.4 Ratings for Trichotillomania (Hair-Pulling Disorder) (Optional; Opt-G.10–Opt-G.12)

Trichotillomania is not part of the core SCID-5. If an assessment of Trichotillomania is needed, insert pages Opt-G.10 through Opt-G.12 between pages G.7 (the last page of OCD) and G.8 (the first page of Other Specified Obsessive-Compulsive and Related Disorder), usually after the pages for Optional Body Dysmorphic Disorder (Opt-G.6–Opt-G.9) if that is being assessed.

Criterion A—Hair pulling resulting in hair loss: There are two components to this criterion: 1) there must be recurrent episodes of hair pulling, and 2) the hair pulling must result in hair loss. Because some individuals pull hair out in a widely distributed pattern (i.e., pulling single hairs from all over a site), the hair loss may not be clearly visible. According to the DSM-5 text (pp. 251–252), hair pulling may occur from any region of the body in which hair grows. The most common sites are the scalp, eyebrows, and eyelids; less common sites are axillary, facial, pubic, and perirectal regions. Hair-pulling sites may vary over time. Hair pulling may occur in brief episodes scattered throughout the day or during less frequent but more sustained periods that can continue for hours. Some individuals attempt to conceal or camouflage hair loss (e.g., by using makeup, scarves, or wigs). Pulling out hair for purely cosmetic reasons is normative, and such behavior alone would justify a rating of "1."

Criterion B—Attempts to decrease or stop hair pulling: The subject must have repeatedly tried to cut down or stop hair pulling in order to qualify for this criterion.

Criterion C—The hair pulling causes clinically significant distress or impairment: As is done throughout the SCID-5 when assessing clinical significance, the interviewer starts by asking an open-ended question to determine the impact that hair-pulling symptoms have had on the subject's life. The follow-up questions are optional. These questions should be asked only if it is not clear from the subject's answers whether the symptoms interfere with functioning.

Criterion D—The hair pulling or hair loss is not attributable to another medical condition (e.g., a dermatological condition). Trichotillomania is not diagnosed if the hair pulling or hair loss is attributable to a GMC (e.g., inflammation of the skin or other dermatological condition).

Criterion E—Not better explained by another mental disorder: If the hair pulling is better explained by another mental disorder (e.g., attempts to improve a perceived defect or flaw in appearance in Body Dysmorphic Disorder, or in response to a delusion or hallucination in a Psychotic Disorder), a diagnosis of Trichotillomania is not given.

Ratings for Trichotillomania Chronology: The assessment of the Trichotillomania criteria up to this point has focused on lifetime Trichotillomania. The Trichotillomania Chronology section serves to determine whether criteria are currently met for Trichotillomania (i.e., in the past month) and, if not, how long it has been since the subject last had any symptom of Trichotillomania. Rather than repeating the assessment of each Trichotillomania criterion for the current month, the SCID-5 only requires a determination of whether or not there has been hair pulling in the past month (Criterion A), whether the subject attempted to cut down or stop hair pulling (Criterion B), and whether it has caused clinically significant distress or impairment (Criterion C).

11.11.5 Ratings for Excoriation (Skin-Picking) Disorder (Optional; Opt-G.13–Opt-G.15)

Excoriation Disorder is not part of the core SCID-5. If an assessment of Excoriation Disorder is needed, insert pages Opt-G.13 through Opt-G.15 between pages G.7 (the last page of OCD) and G.8 (the first page of Other Specified Obsessive-Compulsive and Related Disorder), usually after the pages for Optional Trichotillomania (Opt-G.10–Opt-G.12) if that is being assessed.

Criterion A—Recurrent skin picking resulting in skin lesions: This criterion requires subjects' current picking at their own skin (e.g., with fingernails, tweezers, pins, or other objects), which creates noticeable damage, often due to scratches, sores, scabs or infection. The most commonly picked sites are the face, arms, and hands, but many individuals pick from multiple body sites. Individuals may pick at healthy skin, at minor skin irregularities, at lesions such as pimples or calluses, or at scabs from previous picking. Although this criterion requires that skin picking lead to skin lesions, some individuals with this disorder attempt to conceal or camouflage such lesions (e.g., with makeup or clothing).

Criterion B—Attempts to decrease or stop skin picking: The subject must have repeatedly tried to cut down or stop skin picking in order to qualify for this criterion.

Criterion C—The skin picking causes clinically significant distress or impairment: As is done throughout the SCID-5 when assessing clinical significance, the interviewer starts by asking an open-ended question to determine the impact that skin-picking symptoms have had on the subject's life. The additional follow-up questions are optional and specifically cover various domains of functioning that might be impacted by the skin picking. These questions should be asked only if it is not clear from the subject's answers whether the symptoms interfere with functioning.

Criterion D—Not due to a GMC and not substance/medication-induced: This item instructs the interviewer to consider and rule out a dermatological condition or a substance/medication as an etiological factor for the skin picking, in which case Obsessive-Compulsive and Related Disorder Due to Another Medical Condition or Substance/Medication-Induced Obsessive-Compulsive and Related Disorder is diagnosed. See Section 10, "Differentiating General Medical and Substance/Medication Etiologies From Primary Disorders," in this User's Guide for a general discussion of how to apply this criterion, as well as how to assess the criteria for Obsessive-Compulsive and Related Disorder Due to Another Medical Condition and Substance/Medication-Induced Obsessive-Compulsive and Related Disorder.

Criterion E—Not better explained by another mental disorder: If the skin picking is better explained by another mental disorder (e.g., delusions or tactile hallucinations in a Psychotic Disorder, attempts to

improve a perceived defect or flaw in appearance in Body Dysmorphic Disorder, stereotypies in Stereotypic Movement Disorder, or intention to harm oneself in nonsuicidal self-injury), a diagnosis of Excoriation Disorder is not given.

Ratings for Excoriation Disorder Chronology: The assessment of the Excoriation Disorder criteria up to this point has focused on lifetime Excoriation Disorder. The Excoriation Disorder Chronology section serves to determine whether criteria are currently met for Excoriation Disorder (i.e., in the past month) and, if not, how long it has been since the subject last had any symptom of Excoriation Disorder. Rather than repeating the assessment of each Excoriation Disorder criterion for the current month, the SCID-5 requires only a determination of whether or not there has been skin picking in the past month that causes skin lesions (Criterion A), whether the subject attempted to cut down or stop skin picking (Criterion B), and whether it is causing clinically significant distress or impairment (Criterion C).

11.11.6 Ratings for Other Specified Obsessive-Compulsive and Related Disorder (G.8–G.10)

If there are symptoms characteristic of an Obsessive-Compulsive and Related Disorder that do not meet criteria for OCD, Hoarding Disorder, Body Dysmorphic Disorder, Trichotillomania, or Excoriation Disorder, then Other Specified Obsessive-Compulsive and Related Disorder should be considered. The paragraph defining this disorder in DSM-5 (pp. 263–264) has been converted into a set of four ratings in the SCID-5.

Symptoms characteristic of an Obsessive-Compulsive and Related Disorder: This item indicates that this category is intended for presentations that include obsessions, compulsions, preoccupation with a defect in bodily appearance, other preoccupations (e.g., obsessive jealousy), and other body-focused repetitive behaviors (e.g., nail biting) that do not meet the full criteria for OCD (diagnosed in Module G) or Hoarding Disorder, Body Dysmorphic Disorder, Trichotillomania, or Excoriation Disorder (optionally diagnosed in Module G).

Symptoms cause clinically significant distress or impairment: This item clarifies that all of the DSM-5 Other Specified categories must meet the basic requirement that the symptoms be sufficiently severe as to have a negative impact on the subject's life.

Not due to a GMC and not substance/medication-induced: This item instructs the interviewer to consider and rule out a GMC or a substance/medication as an etiological factor for the Obsessive-Compulsive and Related Disorder symptoms, in which case an Obsessive-Compulsive and Related Disorder Due to Another Medical Condition or Substance/Medication-Induced Obsessive-Compulsive and Related Disorder is diagnosed. Note that the descriptions of Other Specified (and Unspecified) Obsessive-Compulsive and Related Disorders in DSM-5 do not specifically require that general medical or substance/medication etiologies be ruled out. The requirement to rule out such etiologies has been added to the SCID-5-RV to ensure that subthreshold presentations due to a GMC or substance/medication get properly diagnosed. See Section 10, "Differentiating General Medical and Substance/Medication Etiologies From Primary Disorders," in this User's Guide for a general discussion of how to apply this criterion, as well as how to assess the criteria for Obsessive-Compulsive and Related Disorder Due to Another Medical Condition and Substance/Medication-Induced Obsessive-Compulsive and Related Disorder.

Indication of the type of symptomatic presentation: The first four examples in DSM-5 of presentations that can be specified using the Other Specified designation (supplemented by three additional SCID-specific examples) are included. For specified obsessive-compulsive and related presentations not covered by one of these examples, the Other Specified designation is used, in which case the interviewer should record the specific reason that the criteria for one of the Obsessive-Compulsive and Related Disorders were not met. For presentations in which there is insufficient information to make a more specific diagnosis, Unspecified Type should be recorded.

11.12 Module H. Sleep-Wake Disorders (Optional)

Module H assesses the Sleep-Wake Disorders, which include current Insomnia Disorder, current Hypersomnolence Disorder, and Substance/Medication-Induced Sleep Disorder. This module is not part of the core SCID-5. If an assessment of Sleep-Wake Disorders is needed, insert pages Opt-H.1 through Opt-H.11 between pages G.16 (the last page of Module G) and I.1 (the first page of the Feeding and Eating Disorders module). Note that these pages are physically located in the Optional Disorders Repository file (see Section 5, "Steps for Customizing the SCID-5-RV for Your Study," in this User's Guide for an explanation of how to customize the SCID-5).

11.12.1 Ratings for Current Insomnia Disorder (Optional; Opt-H.1–Opt-H.4)

The assessment of Insomnia Disorder in the SCID-5 is limited to the current period only because of the requirement that the complaint of dissatisfaction with sleep quality or quantity be "predominant" and the difficulty of reliably identifying a 3-month period of past Insomnia Disorder. Given the requirement of a minimum 3-month duration, current Insomnia Disorder is defined as occurring over the past 3 months. Note that Criterion F has intentionally been placed at the end of the Insomnia Disorder criteria set because whether the rating for Criterion F is "?" or "3" determines whether the Insomnia Disorder diagnosis is "provisional" or "definite."

Criterion A—Predominant complaint of dissatisfaction with sleep: Criterion A has been split into two parts. The first part covers the DSM-5 requirement that insomnia be "a predominant complaint." Consequently, the screening question inquires whether the problem sleeping has been a "major concern" of the subject. If the insomnia has not been a focus of the subject's presenting complaints, this item should be rated "1" and the interviewer should skip to the assessment of Hypersomnolence Disorder. The second part of this criterion inquires about the specifics of the subject's sleep difficulty over the past 3 months. The interviewer first asks the subject open-ended questions to determine typical bedtime and awake time during the past 3 months (i.e., "What time have you usually gone to sleep? What time have you usually woken up for the last time each morning?"). These are followed by specific questions covering the three subcomponents of Criterion A. The DSM-5 text for Insomnia Disorder includes "additional criteria [that] are useful to quantify insomnia severity" (p. 364), noting, however, that "these quantitative criteria, while arbitrary, are provided for illustrative purposes only." According to the DSM-5 text (p. 364), difficulty initiating sleep is defined by a subjective sleep latency greater than 20–30 minutes, and difficulty maintaining sleep is defined by a subjective time awake after sleep onset greater than 20–30 minutes. Consequently, in order to enhance diagnostic reliability, the questions for Criterion A1 (difficulty initiating sleep) and Criterion A2 (difficulty maintaining sleep) ask whether the trouble falling asleep or periods of middle-of-the-night wakefulness have lasted at least 30 minutes. Similarly, based on the statement in the text (p. 364) that "early-morning awakening... involves awakening at least 30 minutes before the scheduled time and before total sleep time reaches 6½ hours," both of these parameters are included in the rating for Criterion A3. As noted in the DSM-5 text (p. 364)—

> It is essential to take into account not only the final awakening time but also the bedtime on the previous evening. Awakening at 4:00 A.M. does not have the same clinical significance in those who go to bed at 9:00 P.M. as in those who go to bed at 11:00 P.M. Such a symptom may also reflect an age-dependent decrease in the ability to sustain sleep or an age-dependent shift in the timing of the main sleep period.

Criterion B—Sleep disturbance causes clinically significant distress or impairment: As is done throughout the SCID-5 when assessing clinical significance, the interviewer starts by asking an open-ended question to determine the impact that the insomnia has had on the subject's life. The additional follow-up questions below this criterion are optional and specifically cover various domains of functioning that might be impacted by the insomnia. These questions should be asked only if it is not clear from the subject's answers whether the symptoms interfere with functioning. Note the addition of some insomnia-specific questions regarding the impact of the sleep disturbance on the person's ability to drive safely and to operate machinery.

Criteria C and D—At least 3 nights per week for at least 3 months: These criteria have been combined in the SCID-5 because there was no need for a separate Criterion D ("present for at least 3 months"). Both the screening questions and the questions pertaining to Criterion A have already been framed in terms of the past 3 months.

Criterion E—Not due to inadequate opportunity: The phrase "inadequate opportunity for sleep" includes both environmental factors that might make it difficult to sleep (e.g., too much noise or light, uncomfortable temperature or bedding) and personal factors, such as the subject not having enough time in his or her schedule for adequate sleep (e.g., being up all night tending to a sick child).

Criterion G—Not due to a substance: This item instructs the interviewer to consider and rule out a substance/medication as an etiological factor for the insomnia, in which case Substance/Medication-Induced Sleep Disorder is diagnosed. See Section 10.2, "Assessing Substance/Medication-Induced Disorders," in this User's Guide for a general discussion of how to apply this criterion, as well as how to assess the criteria for Substance/Medication-Induced Sleep Disorder. Note that unlike other similar "rule out" criteria throughout the SCID, this criterion only rules out sleep disturbances that are due to substances/medications. Insomnia related to a GMC is still diagnosed as Insomnia Disorder in DSM-5 (i.e., there is no "Sleep Disorder Due to Another Medical Condition" in DSM-5, because of the difficulty in determining whether the sleep disturbance is caused by a GMC or simply is associated with it).

Criterion H—Coexisting mental disorders and medical conditions do not adequately explain predominant complaint of insomnia: Many mental disorders and GMCs may be associated with insomnia. When insomnia occurs in the presence of a coexisting mental disorder or GMC, the insomnia should be considered "not adequately explained" only if the insomnia was present at times when the subject was *not* suffering from the comorbid mental disorder or GMC, or the insomnia is sufficiently severe that it warrants independent clinical attention.

Criterion F—*Not better explained by and does not occur exclusively during the course of another Sleep-Wake Disorder:* The differential diagnosis of Insomnia Disorder includes a number of other Sleep-Wake Disorders, including Narcolepsy, Breathing-Related Sleep Disorders (e.g., Obstructive Sleep Apnea), Circadian Rhythm Sleep-Wake Disorders, Parasomnias, and Restless Legs Syndrome. If the insomnia is better explained by another Sleep-Wake Disorder or occurs exclusively during the course of another Sleep-Wake Disorder, then an additional diagnosis of Insomnia Disorder is not given. Practically speaking, however, this criterion can only be applied after the other Sleep-Wake Disorders that could be responsible for the Insomnia Disorder have been ruled out. Some Sleep-Wake Disorders, such as Breathing-Related Sleep Disorders and Narcolepsy, require polysomnography in order to rule them out definitively. If the subject has not had such an investigation, it may not be possible to rate this criterion as either a "1" or a "3," and the "?" should be coded instead.

SPECIFIERS FOR SLEEP-WAKE DISORDERS

PROVISIONAL or DEFINITE SUBTYPE: The diagnosis of Insomnia Disorder is made in the SCID-5 without taking into account the rating of Criterion F. This subtype indicates whether or not the interviewer has sufficient information to determine definitely whether the insomnia is, or is not, better explained by/occurs exclusively during another Sleep-Wake Disorder. If it is not possible to rate Criterion F either a "1" or a "3" (i.e., it was rated "?"), then the Provisional subtype is selected, indicating that the Insomnia Disorder diagnosis is only provisional. If Criterion F is rated "1" or "3," then the Definite subtype is selected, indicating that the diagnosis of Insomnia Disorder is definite. Note that this subtype is not included in DSM-5 but has been added to the SCID-5 to allow for a provisional diagnosis of Insomnia Disorder in cases where a full workup to rule out other explanatory sleep disorders has not been done.

ASSOCIATED CONDITIONS SPECIFIERS: These specifiers allow the interviewer to indicate the mental disorders, GMCs, or other Sleep-Wake Disorders coexisting with the current Insomnia Disorder. As noted in the diagnostic criteria for Insomnia Disorder, an independent diagnosis of Insomnia Disorder is given only if the insomnia is not adequately explained by the coexisting mental disorders and GMCs and if the insomnia occurs at times other than just during another Sleep-Wake Disorder.

COURSE SPECIFIER: The Recurrent specifier allows the interviewer to indicate whether or not there has been more than one episode of Insomnia Disorder (i.e., each episode lasting at least 3 months) in the past year. Two other course specifiers included in DSM-5 (Episodic and Persistent) have been omitted from the SCID-5: the definition of Episodic (episodes lasting between 1 month and less than 3 months) is inconsistent with the DSM-5 requirement that all cases of Insomnia Disorder last at least 3 months (as per Criterion D), and the definition of Persistent (symptoms last longer than 3 months) renders it superfluous, as all cases of Insomnia Disorder qualify as persistent by definition.

11.12.2 Ratings for Current Hypersomnolence Disorder (Optional; Opt-H.5–Opt-H.8)

The assessment of Hypersomnolence Disorder in the SCID-5 is limited to the current period only because of the difficulty of reliably identifying a 3-month period of past Hypersomnolence Disorder. Given the requirement of a minimum 3-month duration, current Hypersomnolence Disorder is defined as occurring over the past 3 months. Note that Criterion D has intentionally been placed at the end of the Hypersomnolence Disorder criteria set because whether the rating for Criterion D is "?" or "3" determines whether the Hypersomnolence Disorder diagnosis is "provisional" or "definite."

Criterion A—Self-reported excessive sleepiness and associated symptoms: Criterion A has two components. The first component covers the requirement of self-reported excessive sleepiness despite a main sleep period lasting at least 7 hours. Although the criterion itself does not include any frequency or persistence requirements, the question uses the word "often" to reflect the requirement in Criterion B that the hypersomnolence occurs at least three times per week. Although in most cases the subject's typical sleep time and awake time will have been determined as part of the assessment of Insomnia Disorder, in case this information has not yet been adequately assessed, questions inquiring about this have been included.

The second component of Criterion A addresses the presence of associated hypersomnolence symptoms, at least one of which is required for this criterion to be met. The first item, "recurrent periods of sleep or lapses into sleep within the same day" is referring to the occurrence of unintentional daytime naps. According to the DSM-5 text, these daytime naps "tend to be relatively long (often lasting

1 hour or more), are experienced as nonrestorative (i.e., unrefreshing), and do not lead to improved alertness" (p. 369). The second item refers to the subject's experience that despite sleeping at least 9 hours, the subject wakes up feeling tired and unrefreshed. The third item describes the phenomenon of "sleep inertia," in which the subject has difficulty being fully awake after an abrupt awakening, either from the main sleep episode or from a daytime nap. According to the DSM-5 text (p. 369), such individuals—

> may have difficulty waking up in the morning, sometimes appearing confused, combative, or ataxic…. The individual appears awake, but there is a decline in motor dexterity, behavior may be very inappropriate, and memory deficits, disorientation in time and space, and feelings of grogginess may occur.

Criterion B—At least three times per week for at least 3 months: This frequency/duration criterion requires that the hypersomnolence must have occurred at least three times per week for at least 3 months.

Criterion C—Sleep disturbance causes clinically significant distress or impairment: As is done throughout the SCID-5 when assessing clinical significance, the interviewer starts by asking an open-ended question to determine the impact that the hypersomnolence has had on the subject's life. The additional follow-up questions are optional and specifically cover various domains of functioning that might be impacted by the hypersomnolence. These questions should be asked only if it is not clear from the subject's answers whether the symptoms interfere with functioning. Note the addition of some hypersomnolence-specific questions regarding the impact of the sleep disturbance on the person's ability to drive safely and to operate machinery.

Criterion E—Not due to a substance: This item instructs the interviewer to consider and rule out a substance/medication as an etiological factor for the hypersomnolence, in which case Substance/Medication-Induced Sleep Disorder is diagnosed. See Section 10.2, "Assessing Substance/Medication-Induced Disorders," in this User's Guide for a general discussion of how to apply this criterion, as well as how to assess the criteria for Substance/Medication-Induced Sleep Disorder. Note that unlike other similar rule-out criteria throughout the SCID, this criterion only rules out sleep disturbances that are due to substance/medications. Hypersomnolence related to a GMC is still diagnosed as Hypersomnolence Disorder in DSM-5 (i.e., there is no Sleep Disorder Due to Another Medical Condition in DSM-5 because of the difficulty in determining whether the sleep disturbance is caused by a GMC or simply is associated with it).

Criterion F—Coexisting mental disorders and concurrent medical conditions do not adequately explain predominant complaint of hypersomnolence: Many mental disorders and GMCs may be associated with hypersomnolence. When hypersomnolence occurs in the presence of a coexisting mental disorder or GMC, the hypersomnolence should be considered "not adequately explained" only if the hypersomnolence was present at times when the subject was *not* suffering from the comorbid mental disorder or GMC, or if the hypersomnolence is sufficiently severe that it warrants independent clinical attention.

Criterion D—Not better explained by and does not occur exclusively during the course of another Sleep-Wake Disorder: The differential diagnosis of Hypersomnolence Disorder includes a number of other Sleep-Wake Disorders, including Narcolepsy, Breathing-Related Sleep Disorders (e.g., Obstructive Sleep Apnea), Circadian Rhythm Sleep-Wake Disorders, Parasomnias, and Restless Legs Syndrome. If the hypersomnolence is better explained by another Sleep-Wake Disorder or occurs exclusively during the course of another Sleep-Wake Disorder, then an additional diagnosis of Hypersomnolence Disorder is

not given. Practically speaking, however, this criterion can only be applied after other Sleep-Wake Disorders that could be responsible for the hypersomnolence have been ruled out. Some Sleep-Wake Disorders, such as Breathing-Related Sleep Disorders and Narcolepsy, require polysomnography in order to definitely rule them out. If the subject has not had such an investigation, it may not be possible to rate this criterion as either a "1" or a "3," and the "?" should be coded instead.

SPECIFIERS FOR HYPERSOMNOLENCE DISORDER

PROVISIONAL or DEFINITE SUBTYPE: The diagnosis of Hypersomnolence Disorder is made without taking into account the rating of Criterion D. This subtype indicates whether or not the interviewer has sufficient information to determine definitely whether the hypersomnolence is, or is not, better explained by/occurs exclusively during another Sleep-Wake Disorder. If it is not possible to rate Criterion D either a "1" or a "3" (i.e., it was rated "?"), then the Provisional subtype is selected, indicating that the Hypersomnolence Disorder diagnosis is only provisional. If Criterion D is rated "1" or "3," then the Definite subtype is selected, indicating that the diagnosis of Hypersomnolence Disorder is definite. Note that this subtype is not included in DSM-5 but has been added to the SCID-5 to allow for a provisional diagnosis of Hypersomnolence Disorder in cases where a full workup to rule out other explanatory sleep disorders has not been done.

ASSOCIATED CONDITIONS SPECIFIERS: These specifiers allow the interviewer to indicate mental disorders, GMCs, or other Sleep-Wake Disorders occurring concurrently with the current 3-month period of Hypersomnolence Disorder. As noted in the diagnostic criteria for Hypersomnolence Disorder, an independent diagnosis of Hypersomnolence Disorder is given only if the hypersomnolence is not adequately explained by the coexisting mental disorders and GMCs, and if the hypersomnolence occurs at times other than just during another Sleep-Wake Disorder.

SEVERITY SPECIFIERS: The severity of current Hypersomnolence Disorder (i.e., Mild, Moderate, Severe) is based on how many days per week, on average, the subject has had difficulty maintaining daytime alertness.

COURSE SPECIFIERS: Note that DSM-5 includes three course specifiers: Acute (duration of less than 1 month); Subacute (duration of 1–3 months); and Persistent (.e., duration of more than 3 months). These have been omitted from the SCID-5. The first two (Acute and Subacute) cannot apply to the diagnosis of Hypersomnolence Disorder given the requirement of a minimum duration of 3 months.

11.13 Module I. Feeding and Eating Disorders

Module I assesses current and lifetime Anorexia Nervosa, Bulimia Nervosa, Binge-Eating Disorder, and Other Specified Feeding or Eating Disorder, as well as the optional assessment of Avoidant/Restrictive Food Intake Disorder. The time frame used for current Anorexia Nervosa, Bulimia Nervosa, and Binge-Eating Disorder in the SCID-5 is the past 3 months. The optional assessment of Avoidant/Restrictive Food Intake Disorder is for the current period only and is set as 1 month in the SCID.

The format used thus far in the SCID-5 has involved assessing criteria for lifetime and current periods separately, for the sake of efficiency. In contrast, the method used in Module I for the evaluation of Anorexia Nervosa, Bulimia Nervosa, and Binge-Eating Disorder is to assess each criterion first for lifetime and then for current. Thus, each item is rated twice: first a rating is given for lifetime occurrence. If the lifetime rating is rated "3," a second rating is given to indicate whether that criterion has also been present in the past 3 months based on a follow-up question (e.g., "Has this also been the case during the past 3 months?").

11.13.1 Ratings for Anorexia Nervosa (I.1–I.3)

Criterion A—Restriction of energy intake leading to low body weight: The individual maintains a body weight that is below a minimally normal level for age, sex, developmental trajectory, and physical health. The determination as to whether the person's weight is being maintained at a significantly below-normal level is a clinical judgment. When making this determination, it is useful to determine the subject's body mass index (BMI), calculated as weight in kilograms/height in meters^2 or, alternatively, weight in pounds/height in inches^2 x 703. According to the DSM-5 text (p. 340)—

> For adults, a BMI of 18.5 kg/m^2 has been employed by the Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO) as the lower limit of normal body weight. Therefore, most adults with a BMI greater than or equal to 18.5 kg/m^2 would not be considered to have a significantly low body weight. On the other hand, a BMI of lower than 17.0 kg/m^2 has been considered by the WHO to indicate moderate or severe thinness; therefore, an individual with a BMI less than 17.0 kg/m^2 would likely be considered to have a significantly low weight. An adult with a BMI between 17.0 and 18.5 kg/m^2, or even above 18.5 kg/m^2, might be considered to have a significantly low weight if clinical history or other physiological information supports this judgment.

Criterion B—Intense fear of gaining weight: Most individuals with Anorexia Nervosa report an intense fear of gaining weight or of becoming fat, which is usually not alleviated by losing weight. Some individuals with Anorexia Nervosa, especially those who are younger, may not recognize or acknowledge a fear of weight gain. In the absence of another explanation for a significantly low weight, clinical inference about this criterion can be drawn from the presence of persistent behaviors that prevent weight gain even though underweight, such as strictly avoiding high-calorie foods or engaging in vigorous exercise after eating,

Criterion C—Distorted perceptions about body weight or lack of recognition of seriousness of low weight: This criterion includes three forms of characteristically 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) the person's body shape and weight are the central factor in determining self-esteem, and 3) lack of recognition of the serious medical implications of his or her malnourished state.

Ratings for Anorexia Nervosa Chronology: At the conclusion of the criterion ratings, two summary ratings are made. The first one, "ANOREXIA NERVOSA CRITERIA A, B, AND C ARE CODED '3'" reflects the lifetime coding for the three Anorexia Nervosa criteria (i.e., the first of the two ratings for each criterion). The second one, "ANOREXIA NERVOSA CRITERIA A, B, AND C ARE CODED '3' FOR THE PAST 3 MONTHS" reflects just the coding for the boxes labeled "past 3 months" and determines whether the Anorexia Nervosa is considered to be "current" or "past." If it is current, the appropriate severity specifier as well as current subtype (restricting type vs. binge-eating/purging type) should be applied. If the Anorexia Nervosa is past, the appropriate remission specifier should be indicated.

SPECIFIERS FOR ANOREXIA NERVOSA

SEVERITY SPECIFIERS: The severity of current Anorexia Nervosa is based on the subject's current BMI, which is calculated based on measurements of height and current weight, as well as a consideration of current clinical symptoms, degree of functional disability, and the need for supervision. Refer to the "Table for Determining Severity of Anorexia Nervosa Based on Body Mass Index" on page I.12 for the determination of the severity of Anorexia Nervosa based on BMI.

REMISSION SPECIFIERS: These specifiers apply only in cases in which current criteria for Anorexia Nervosa are not met. In Partial Remission applies if the weight criterion has not been met for a sustained period of time (e.g., BMI is above 17 kg/m^2) but either of the other two criteria (fear of gaining weight/behavior that interferes with weight gain or disturbances in self-perception of weight and shape) are still met. In Full Remission applies if none of the criteria for Anorexia Nervosa have been met for a sustained period of time. Although DSM-5 does not provide any indication of what is meant by a "sustained period of time," for the purpose of improving reliability, 12 months would be a reasonable time period to use.

SUBTYPES: Presentations of Anorexia Nervosa are divided into two mutually exclusive subtypes based on whether or not the individual has engaged in recurrent episodes of binge-eating or purging behavior: Restricting Type is for current presentations (i.e., over the past 3 months) without recurrent episodes of binge eating or purging, and the Binge-Eating/Purging Type is for presentations in which the individual has engaged in recurrent binge-eating or purging behavior.

11.13.2 Ratings for Bulimia Nervosa (I.4–I.6)

Criterion A—Binge eating: There are two parts to this criterion: the first part describes the eating behavior that characterizes a binge (i.e., eating, in a discrete period of time, an amount of food that is definitely larger than most people would eat during a similar period of time), and the second part describes the individual's sense of loss of control over what or how much he or she is eating. Given that the screening question for Bulimia Nervosa inquires about times when the person's eating was out of control, the order of these two components has been reversed so that the loss of control criterion comes first to correspond to the content of the screening question.

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). The type of food consumed during binges varies, but usually includes sweet, high-calorie treats such as cookies, ice cream, or cake. A single episode of binge eating need not be restricted to one setting. For example, an individual may begin a binge in a restaurant and then continue to eat on returning home. Continual snacking on small amounts of food

throughout the day would not be considered an eating binge. Because 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.

According to the DSM-5 text (p. 346), loss of control over eating is indicated by being unable to—

> refrain from eating or to stop eating once it is started. The impairment in control associated with binge eating may not be absolute; for example, an individual may continue binge eating while the telephone is ringing but will cease if a roommate or spouse unexpectedly enters the room. Some individuals report that their binge-eating episodes are no longer characterized by an acute feeling of loss of control but rather by a more generalized pattern of uncontrolled eating. If individuals report that they have abandoned efforts to control their eating, loss of control should be considered to be present.

Criterion B—Inappropriate compensatory behavior: 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 misuse of laxatives, diuretics, or enemas). Less common compensatory behaviors include fasting, excessive exercise, and manipulation of insulin doses by diabetics. Individuals are often very embarrassed about both their binge eating and their compensatory mechanisms (particularly those related to purging). Such information may therefore not be volunteered and may emerge only with direct questioning.

Criterion C—Occurs, on average, at least once a week for 3 months: 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—Self-evaluation unduly influenced by body shape and weight: This criterion is similar to the component in Criterion C of Anorexia Nervosa in which there is an undue influence of body weight or shape on self-evaluation. Individuals with Bulimia Nervosa place an excessive emphasis on body shape or weight in their self-evaluation, and these factors are typically extremely important in determining self-esteem.

Criterion E—Not exclusively during episodes of Anorexia Nervosa: Binge eating and purging often occur in the context of Anorexia Nervosa; this is reflected in the fact that the subtyping scheme for Anorexia Nervosa is based on the presence or absence of episodes of recurrent binge eating or purging behavior. When this behavior occurs only during episodes of Anorexia Nervosa, an additional diagnosis of Bulimia Nervosa is not given. If, however, there are episodes lasting at least 3 months in which there is recurrent binge eating and the use of inappropriate compensatory mechanisms at times when the person's weight is not significantly low, according to DSM-5 (p. 349) an additional diagnosis of Bulimia Nervosa may be given to reflect the individual's clinical status during those times.

Ratings for Bulimia Nervosa Chronology: At the conclusion of the criterion ratings, two summary ratings are made. The first one, "BULIMIA NERVOSA CRITERIA A, B, C, D, AND E ARE CODED '3'" reflects the lifetime coding for the five Bulimia Nervosa criteria (i.e., the first of the two ratings for each criterion). The second one, "BULIMIA NERVOSA CRITERIA A, B, C, D, AND E ARE CODED '3' FOR THE PAST 3 MONTHS" reflects just the coding for the boxes labeled "past 3 months" and determines whether the Bulimia Nervosa is considered to be "current" or "past." If it is current, the appropriate severity specifier should be applied. If the Bulimia Nervosa is past, the appropriate remission specifier should be indicated.

SPECIFIERS FOR BULIMIA NERVOSA

SEVERITY SPECIFIERS: The severity of current Bulimia Nervosa is based on the average number of inappropriate compensatory behaviors per week for the past 3 months, as well as a consideration of current clinical symptoms and the degree of functional disability: Mild applies if there has been an average of 1–3 episodes per week; Moderate if there has been an average of 4–7 episodes per week; Severe if there has been an average of 8–13 episodes per week; and Extreme if there has been an average of 14 or more episodes per week.

REMISSION SPECIFIERS: These specifiers apply only in cases where current criteria for Bulimia Nervosa are not met. In Partial Remission applies when some but not all of the criteria have been met for a sustained period of time (e.g., recurrent binge eating without use of inappropriate compensatory mechanisms). In Full Remission applies if none of the criteria have been met for a sustained period of time. Although DSM-5 does not provide any indication of what is meant by a "sustained period of time," for the purpose of improving reliability, 12 months would be a reasonable time period to use.

11.13.3 Ratings for Binge-Eating Disorder (I.7–I.9)

The assessment of Binge-Eating Disorder begins with Criterion B. It has the same Criterion A as Bulimia Nervosa. Criterion A was already rated "3" (on page I.4) during the course of the evaluation of Bulimia Nervosa, which was followed by a rating of "1" for Bulimia Nervosa Criterion B (top of page I.5), which triggered a skip to the evaluation of Binge-Eating Disorder.

Criterion B—Binge eating associated with three or more items: Three or more out of the list of five features associated with binge eating (i.e., eating more rapidly than normal; eating until feeling uncomfortably full; eating large amounts of food when not physically hungry; eating alone because of being embarrassed; feeling disgusted with oneself, depressed, or very guilty) must be present. Note that the questions corresponding to the "past 3 months" rating should only be asked if the subject has been binge eating during the past 3 months, a fact that was determined during the rating of the binge-eating item (Criterion A) in the assessment of Bulimia Nervosa (page I.4).

Criterion C—Marked distress about binge eating: Note that this version requires only marked distress, unlike the typical "marked distress or impairment" criterion that is used throughout DSM-5.

Criterion D—Binge eating occurs at least weekly for 3 months: This reflects an average frequency of weekly over the past 3 months, which matches the minimum frequency for Bulimia Nervosa.

Criterion E—Not associated with inappropriate compensatory mechanisms and not exclusively during Bulimia Nervosa or Anorexia Nervosa: Given that the evaluation of Binge-Eating Disorder was triggered by a rating of "1" for Bulimia Nervosa Criterion B (i.e., recurrent inappropriate compensatory behavior in order to prevent weight gain), the first part of this criterion is essentially automatically true—the first of the two SCID questions was included just in case there is any lack of clarity about this. The second question, which is also typically unnecessary, confirms that the binge eating did not occur during periods of very low weight.

Ratings for Binge-Eating Disorder Chronology: At the conclusion of the criterion ratings, two summary ratings are made. The first one, "BINGE-EATING DISORDER CRITERIA A, B, C, D, AND E ARE CODED '3'" reflects the lifetime coding for the five Binge-Eating Disorder criteria (i.e., the first of the two ratings for

each criterion). The second one, "BINGE-EATING DISORDER CRITERIA A, B, C, D, AND E ARE CODED '3' FOR THE PAST 3 MONTHS" reflects just the coding for the boxes labeled "past 3 months" and determines whether the Binge-Eating Disorder is considered to be "current" or "past." If it is current, the appropriate severity specifier should be applied. If the Binge-Eating Disorder is past, the appropriate remission specifier should be indicated.

SPECIFIERS FOR BINGE-EATING DISORDER

SEVERITY SPECIFIERS: The severity of current Binge-Eating Disorder is based on the average number of binge eating episodes per week for the past 3 months as well as a consideration of current clinical symptoms and the degree of functional disability: Mild applies if there has been an average of 1–3 episodes per week; Moderate if there has been an average of 4–7 episodes per week; Severe if there has been an average of 8–13 episodes per week; and Extreme if there has been an average of 14 or more episodes per week.

REMISSION SPECIFIERS: These specifiers apply only in cases where current criteria for Binge-Eating Disorder are not met. In Partial Remission applies when binge eating occurs but at a frequency of less than one episode per week for a sustained period of time. In Full Remission applies if none of the criteria have been met for a sustained period of time. Although DSM-5 does not provide any indication of what is meant by a "sustained period of time," for the purpose of improving reliability, 12 months would be a reasonable time period to use.

11.13.4 Ratings for Current Avoidant/Restrictive Food Intake Disorder (Optional; Opt-I.1–Opt-I.3)

Avoidant/Restrictive Food Intake Disorder (ARFID) is not part of the core SCID-5. If an assessment of ARFID is needed, pages Opt-I.1 through Opt-I.3 should be inserted between pages I.9 (the last page of Binge-Eating Disorder) and I.10 (the first page of Other Specified Feeding or Eating Disorder). The assessment of ARFID is limited to the current period only, which is defined as the past 1 month in the SCID.

ARFID was introduced as a new diagnostic category in DSM-5. It describes individuals whose symptoms do not match the criteria for traditional eating disorder diagnoses but who, nonetheless, experience clinically significant struggles with eating and food intake. Symptoms of ARFID typically show up in infancy or childhood, but they may also present in or persist into adulthood. Individuals whose symptoms meet criteria for ARFID have developed some type of problem with eating that has resulted in not ingesting adequate calories or nutrition through their food intake, and they therefore may lose weight. Others with ARFID might need supplements to get adequate calories and nutrition. A variety of eating problems might warrant an ARFID diagnosis, including avoiding certain colors or textures of food, eating only very small portions, having no appetite, and being afraid to eat after a frightening episode of choking or vomiting.

Criterion A (Part I)—Eating or feeding disturbance: This criterion has been split into two parts in the SCID-5, each of which is rated separately, reflecting that it requires both the presence of an eating or feeding disturbance and the presence of negative consequences caused by the eating or feeding disturbance. Creating screening questions for this item was particularly challenging because the "eating or feeding disturbance" leading to low weight or nutritional deficiency is indicated in DSM-5 (p. 334) only with examples ("e.g., apparent lack of interest in eating or food; avoidance based on the sensory

characteristics of food; concern about aversive consequences of eating"). Thus, the three screening questions have been written to cover precisely these situations. Conceivably, however, other situations not covered by these examples and not mentioned in the DSM-5 text could qualify as well. If the interviewer has information from the Overview or other sources that the subject has some other type of eating disturbance, a rating of "3" could be given to cover that as well.

Criterion A (Part II)—Persistent failure to meet appropriate nutritional and/or energy needs: Four items are provided in DSM-5, and the presence of any one is enough to fulfill the second half of Criterion A. Three out of the four items use terms like "significant" and "marked" to indicate the need to apply a severity threshold. The DSM-5 text (p. 334) states that "the determination of whether weight loss is significant…is a clinical judgment" and that the "determination of significant nutritional deficiency…is also based on clinical assessment (e.g., assessment of dietary intake, physical examination, and laboratory testing), and related impact on physical health can be of a similar severity to that seen in Anorexia Nervosa (e.g., hypothermia, bradycardia, anemia)." For "marked interference with psychosocial functioning," examples given in the DSM-5 text (pp. 334–335) include "inability to participate in normal social activities, such as eating with others, or to sustain relationships." Regarding Criterion A3, the DSM-5 text (p. 334) explains that—

> 'Dependence' on enteral feeding or oral nutritional supplements means that supplementary feeding is required to sustain adequate intake. Examples of individuals requiring supplementary feeding include…individuals who rely on gastrostomy tube feeding or complete oral nutrition supplements in the absence of an underlying medical condition.

Criterion B—Not explained by lack of available food or culturally sanctioned practice: ARFID should not be diagnosed if the malnutrition or low weight has a nonpathological (from a mental disorder perspective) explanation. Thus, if the low weight or malnutrition is the result of a lack of sufficient nutritious food (e.g., as a result of extreme poverty) or a consequence of a culturally sanctioned practice such as fasting, this criterion would be rated "1."

Criterion C—Not occurring exclusively during Anorexia Nervosa or Bulimia Nervosa, and no evidence of disturbance in perception of body weight or shape: If criteria are currently met for Anorexia Nervosa or Bulimia Nervosa, then this criterion should be rated "1." Even if the full criteria are not met for Anorexia Nervosa (e.g., because there is no fear of fatness or the interviewer judges the person's weight to not be "significantly below normal" as required in Anorexia Nervosa), a diagnosis of ARFID is also not made if the subject has a disturbed perception of his or her body weight or shape.

Criterion D—Not attributable to a concurrent medical condition or better explained by another mental disorder: There are two circumstances for a "3" rating of Criterion D: 1) there has not been a GMC or mental disorder concurrent with the current ARFID; or 2) the eating disturbance and its consequences are attributable to a concurrent medical condition or are explained by another mental disorder, but the severity of the eating disturbance exceeds that routinely associated with the condition and warrants additional clinical attention. For example, many individuals with Major Depressive Disorder become so uninterested in eating that they can experience a significant weight loss. This criterion allows for an additional diagnosis of ARFID if the eating disturbance is considerably more severe than is typically seen in Major Depressive Disorder and if it warrants additional clinical attention (e.g., enteral feeding to reverse the medical complications of the weight loss).

11.13.5 Ratings for Other Specified Feeding or Eating Disorder (I.10–I.11)

If there are symptoms characteristic of a Feeding and Eating Disorder that do not meet criteria for Anorexia Nervosa, Bulimia Nervosa, Binge-Eating Disorder, or ARFID, then Other Specified Feeding or Eating Disorder should be considered. The paragraph defining this disorder in DSM-5 (pp. 353–354) has been converted into a set of three ratings in the SCID-5.

Symptoms characteristic of a Feeding and Eating Disorder: This item indicates that this category is intended for presentations that include eating disturbances that do not meet the full criteria for Anorexia Nervosa, Bulimia Nervosa, or Binge-Eating Disorder (all diagnosed in Module I) or ARFID (optionally diagnosed in Module I).

Symptoms cause clinically significant distress or impairment: This item clarifies that all of the DSM-5 Other Specified categories must meet the basic requirement that the symptoms be sufficiently severe as to have a negative impact on the subject's life.

Indication of the type of symptomatic presentation: The first five examples in DSM-5 of presentations that can be specified using the Other Specified designation (supplemented by two additional SCID-specific examples) are included. For specified eating presentations not covered by one of these examples, the Other Specified designation is used, in which case the interviewer should record the specific reason that the criteria for one of the Feeding and Eating Disorders were not met. For presentations in which there is insufficient information to make a more specific diagnosis, Unspecified Type should be recorded.

11.14 Module J. Somatic Symptom and Related Disorders (Optional)

Module J is for assessing the Somatic Symptom and Related Disorders. This optional module includes an assessment for current Somatic Symptom Disorder (past 6 months) and current Illness Anxiety Disorder (past 6 months). Module J is not part of the core SCID-5. If an assessment of Somatic Symptom and Related Disorders is needed, insert pages Opt-J.1 through Opt-J.4 between pages I.12 (the last page of Module I, Feeding and Eating Disorders) and K.1 (the first page of Module K, Externalizing Disorders). Note that these pages are physically located in the Optional Disorders Repository file (see Section 5, "Steps for Customizing the SCID-5-RV for Your Study," in this User's Guide for an explanation of how to customize the SCID-5-RV).

11.14.1 Ratings for Current Somatic Symptom Disorder (Optional; Opt-J.1–Opt-J.2)

Criterion A—Distressing somatic symptoms: This criterion requires the presence of one or more somatic symptoms over the past 6 months that are distressing or result in a significant disruption of daily life. Symptoms may be specific (e.g., localized pain) or relatively nonspecific (e.g., fatigue). In some cases, the symptoms represent normal bodily sensations or discomfort that does not generally signify serious disease. However, in other cases the symptoms may be suggestive of a GMC. In contrast to the DSM-IV construct of Somatoform Disorders, there is no requirement in DSM-5 that the somatic symptoms be without an evident medical explanation. As noted in the DSM-5 text (p. 311), "The individual's suffering is authentic, whether or not it is medically explained." All that is required is that the symptoms be either distressing to the individual or disruptive to the individual's daily life.

Criterion B—Excessive thoughts, feelings, or behaviors related to the symptoms or health concern: This criterion requires the presence of at least one of three items: *excessive* thoughts (i.e., the subject's disproportionate and persistent thoughts about the seriousness of his or her symptoms), *excessive* feelings (the subject's persistently high level of anxiety about health or symptoms), and *excessive* behaviors (the subject's excessive time and energy devoted to these symptoms or health concerns). The requirement that one or more of these items be present is all that differentiates the diagnosis of Somatic Symptom Disorder from normative distressing or disruptive somatic symptoms that may be medical in origin. As noted in the DSM-5 text (p. 311)—

> The symptoms may or may not be associated with another medical condition. The diagnoses of Somatic Symptom Disorder and a concurrent medical illness are not mutually exclusive, and these frequently occur together. For example, an individual may become seriously disabled by symptoms of Somatic Symptom Disorder after an uncomplicated myocardial infarction even if the myocardial infarction itself did not result in any disability.

The operative word in assessing this criterion is *excessive.* The interviewer must make a clinical judgment that the subject's thoughts, feelings, or behaviors related to the somatic symptoms are out of proportion with what would be expected. According to the DSM-5 text (p. 311), individuals with Somatic Symptom Disorder—

> appraise their bodily symptoms as unduly threatening, harmful, or troublesome and often think the worst about their health. Even when there is evidence to the contrary, some patients still fear the medical seriousness of their symptoms. In severe Somatic Symptom Disorder, health concerns may assume a central role in the individual's life, becoming a feature of his or her identity and dominating interpersonal relationships.

Criterion C—Persistence (typically more than 6 months): This criterion requires that one or more somatic symptoms be present persistently over a period of at least 6 months. The SCID-5 has operationalized this as "for most of the time in the past 6 months."

SPECIFIERS FOR SOMATIC SYMPTOM DISORDER
WITH PREDOMINANT PAIN: This specifier applies if the somatic symptoms predominantly involve pain.

PERSISTENT: Criterion C requires that the somatic symptoms be "persistent" in all cases of Somatic Symptom Disorder. This specifier applies to cases that are characterized by severe symptoms, marked impairment, and long duration.

CURRENT SEVERITY: The severity specifier is based on the number of Criterion B symptoms that are present (Mild if only one; Moderate and Severe if two or more are present). The Severe specifier is differentiated from the Moderate specifier if in addition to the two or more Criterion B symptoms, there are multiple somatic complaints or one very severe somatic symptom.

11.14.2 Ratings for Current Illness Anxiety Disorder (Optional; Opt-J.3–Opt-J.4)

Criterion A—Preoccupation with having or acquiring a serious illness: The key assessment challenge for the interviewer is deciding whether the individual's concerns about having or acquiring a serious illness reach the level of "preoccupation." For this reason, the follow-up question asks the subject about how much time was spent thinking about having or acquiring a serious illness.

Criterion B (Part I)—Somatic symptoms are not present or only mild: This criterion differentiates Illness Anxiety Disorder from Somatic Symptom Disorder. Most individuals who would have been diagnosed with Hypochondriasis in DSM-IV qualify for a diagnosis of Somatic Symptom Disorder in DSM-5, given that one of the three items in its Criterion B is "disproportionate and persistent thoughts about the seriousness of one's symptoms." Thus, those individuals with distressing somatic symptoms who interpret those symptoms as being evidence of a serious undiagnosed medical illness are diagnosed with Somatic Symptom Disorder. When the preoccupation with having a serious illness occurs in the absence of *significant* somatic symptoms, then Illness Anxiety Disorder is diagnosed instead.

Criterion B (Part II)—If a GMC is present, preoccupation is excessive or disproportionate: Most individuals with Illness Anxiety Disorder are medically healthy. If a physical sign or symptom is present, it is often a normal physiological sensation (e.g., orthostatic dizziness), a benign and self-limited dysfunction (e.g., transient tinnitus), or a bodily discomfort not generally considered indicative of disease (e.g., belching). However, Illness Anxiety Disorder can be diagnosed in the context of a GMC or if the person is at a high risk for developing a GMC (e.g., strong family history of breast cancer) if the person's preoccupation with the GMC (or concern about developing an illness for which he or she is at high risk) is judged to be clearly excessive or disproportionate.

Criterion C—High level of anxiety about health and easily alarmed about personal health status: This criterion has two components that while clearly related, need to be assessed separately. The first part assesses whether, in general, the person has a high level of anxiety about his or her health. The second part focuses on a more specific aspect of that health anxiety, namely, whether the person is easily alarmed about his or her personal health status, such as by hearing about someone else falling ill or reading a health-related news story. Both components are required for a rating of "3."

Criterion D—Excessive health-related behaviors or maladaptive avoidance: Criterion D has two components, which are assessed with separate questions. The first part assesses whether subjects perform excessive health-related behaviors, such as examining themselves repeatedly (e.g., examining their throat in the mirror), researching their suspected disease excessively (e.g., on the Internet), or repeatedly seeking reassurance from family, friends, or physicians. The second component focuses on maladaptive avoidance behavior, such as avoiding doctor appointments, avoiding visiting sick family members, or avoiding activities such as exercising that the individual fears might jeopardize his or her health. Either excessive health-related behaviors or maladaptive avoidance behaviors are needed to rate this criterion "3."

Criterion E—Duration of at least 6 months: Given the 6-month time frame established at the beginning of this section, this criterion can automatically be coded "3."

Criterion F—Not better explained by another mental disorder: Many other mental disorders may be associated with concerns that somatic symptoms might represent serious medical illness. For example, it is typical in Panic Disorder for the individual, at least initially, to become concerned that the panic attack symptoms are indicative of a serious medical illness such as heart problems. In such cases, an additional diagnosis of Illness Anxiety Disorder is not made.

Delusional Disorder, Somatic Type, is separated from the rest of the assessment of Criterion F in the SCID-5 (with its own question) in order to determine the boundary between the overvalued ideas in Illness Anxiety Disorder and the delusions about health in Delusional Disorder. If the person's preoccupation with having an illness is held with a delusional level of conviction, the diagnosis is Delusional Disorder, Somatic Type, rather than Illness Anxiety Disorder. This is in contrast with DSM-5 diagnoses of psychotic forms of Body Dysmorphic Disorder, in which delusional forms are indicated through the use of the With Absent Insight/Delusional Beliefs specifier, rather than qualifying for a separate diagnosis of Delusional Disorder.

11.15 Module K. Externalizing Disorders

Module K includes current adult Attention-Deficit/Hyperactivity Disorder (ADHD; past 6 months) and two optional disorders: current Intermittent Explosive Disorder (past year) and current Gambling Disorder (past year), all new to the SCID-5. Because these three disorders are drawn from three different DSM-5 diagnostic classes (i.e., Neurodevelopmental Disorders; Disruptive, Impulse-Control, and Conduct Disorders; and Substance-Related and Addictive Disorders), they have been grouped together in the SCID-5 under the rubric "Externalizing Disorders."

11.15.1 Ratings for Current Adult Attention-Deficit/Hyperactivity Disorder (K.1–K.6)

The assessment for ADHD begins with two screening questions that are designed to determine whether or not to proceed with the full assessment of the 18 ADHD items: "Over the past several months, have you been easily distracted or disorganized?" and "Over the past several months, have you had a lot of difficulty being patient or sitting still?" If the answer to both questions is "NO" and there is no evidence from the interview up to this point that the subject has had problems with inattention, hyperactivity, or impulsivity in the past 6 months, the interviewer can skip out, either to Intermittent Explosive Disorder (on page Opt-K.1 if that optional disorder is being assessed) or to Module L (Trauma- and Stressor-Related Disorders). These two screening questions are tied to the general constructs of inattention and impulsivity/hyperactivity rather than to any one criterion because of the polythetic nature (i.e., requiring five out of nine items) of the ADHD criteria set in which no single item is absolutely essential to the disorder. This is unlike most of the other screening questions used in the SCID-5, each of which are tied to the initial item in a disorder's monothetic criteria set so that the absence of the criterion signifies that the disorder can be ruled out.

Criterion A1—Five out of nine inattention symptoms have persisted for at least 6 months: When inquiring about the individual inattention items, it is essential for the interviewer to first elicit examples of the behavior constituting the criterion and then ask additional follow-up questions to determine the extent to which the behavior "negatively impacts directly on social and academic/occupational activities" as required in Criterion A1. For example, if the subject answers "YES" to the initial question ("Have you often missed important details or made mistakes at work (or school) or while taking care of things at home?"), the interviewer should then ask the subject to provide examples of this behavior. In some instances, the example illustrates such an obvious negative impact on functioning that a rating of "3" is justified based on the example alone (e.g., "I made so many mistakes as a waitress getting customers' orders wrong that I got fired"). In other instances, where the potential negative impact of the behavior is less clear, additional follow-up questions (e.g., "How much did this affect your ability to do a good job at work?") may be required before a rating for the item can be given. Note that the SCID-5 is using the threshold of five out of nine items, which applies to "older adolescents and adults (age 17 and older)." If the subject is younger than age 17, the threshold of six out of nine items should be employed.

Criterion A2—Five out of nine hyperactive/impulsive symptoms have persisted for at least 6 months: As described above, it is imperative that the interviewer obtain examples of symptoms and determine whether they are sufficiently severe so as to have a direct negative impact on social and academic/ occupational activities as required in Criterion A2. Note that the SCID-5 is using the threshold of five out

of nine items, which applies to older adolescents and adults (age 17 and older). If the subject is younger than age 17, the threshold of six out of nine items should be employed.

Criterion B—Several inattentive or hyperactive-impulsive symptoms were present before age 12: ADHD is a neurodevelopmental disorder that has its onset during childhood. It is therefore important to establish, as per the requirement in this criterion, the presence of at least some of the symptoms before age 12. If the subject has trouble remembering the age at which the symptoms that were coded "3" began, the SCID provides a number of follow-up questions that inquire about problems during school that may be markers of the presence of ADHD symptoms (e.g., "Did teachers complain that you were not paying attention or that you talked too much in class? Were you ever sent to the principal's office because of your behavior? Did your parents complain about your not being able to sit still or that you were very messy or never ready on time?"). Given that adult recall of childhood symptoms tends to be unreliable, it is beneficial to obtain ancillary information if at all possible.

Criterion C—Symptoms are present in two or more settings: It is important to establish that symptoms are present in more than one setting (i.e., not just at work or at school).

Criterion D—Symptoms interfere with or reduce quality of social, academic, or occupational functioning: The interviewer starts by asking an open-ended question to determine the impact that the symptoms have had on the subject's life. The additional follow-up questions are optional and cover various domains of functioning that might be impacted by the ADHD symptoms. These questions should be asked only if it is not clear from the subject's previous answers whether the symptoms interfered with or reduced the quality of social, academic, or occupational functioning.

Criterion E—The symptoms do not occur exclusively during the course of a Psychotic Disorder and are not better explained by another mental disorder: Note that this exclusion has two components. If there is a comorbid psychotic disorder, ADHD cannot be diagnosed if the symptoms occur exclusively during the course of the psychotic disorder. In practical terms, this means that the ADHD should be diagnosed only if the symptoms occurred in childhood, before the onset of the psychotic disorder. For other mental disorders, ADHD should not be diagnosed if the symptoms are better explained by the other mental disorder, a clinical judgment involving a consideration of whether the symptoms of inattention, hyperactivity, or impulsivity are best conceptualized as features of the other mental disorder.

SPECIFIERS FOR ADULT ATTENTION-DEFICIT/HYPERACTIVITY DISORDER

PRESENTATION SPECIFIERS*:* Specifiers are available to indicate the predominant presentation over the past 6 months: Predominantly Inattentive (if Criterion A1 is met but not Criterion A2); Predominantly Hyperactive/Impulsive (if Criterion A2 is met but not Criterion A1); and a Combined Presentation (if both Criterion A1 and Criterion A2 are met).

SEVERITY SPECIFIERS*:* Specifiers are also available to indicate current severity (i.e., Mild, Moderate, Severe), which has been operationalized in the SCID-5 as the severity when the ADHD was at its worst in the past 6 months.

11.15.2 Ratings for Current Intermittent Explosive Disorder (Optional; Opt-K.1–Opt-K.4)

Intermittent Explosive Disorder (IED) is not part of the core SCID-5. If an assessment of IED is needed, insert pages Opt-K.1 through Opt-K.4 between pages K.6 (the last page of ADHD) and L.1 (the first page

of Module L, Trauma and Stressor-Related Disorders). Note that a 12-month time frame has been used for "current" to accommodate the three severe outbursts in a 12-month period required in Criterion A1.

Two screening questions are included for current IED: one to cover verbal aggression ("In the past year, since [ONE YEAR AGO], have you frequently lost control of your temper and ended up yelling or getting into arguments with others?") and the other to cover physical aggression ("In the past year, have you lost your temper so that you shoved, hit, kicked, or threw something at a person or an animal or damaged someone's property?").

Criterion A—Recurrent behavioral outbursts representing a failure to control aggressive impulses: This criterion establishes two different frequency thresholds based on the severity of the aggressive impulses: 1) three aggressive outbursts in a 12-month period if the outbursts result in damage or destruction of property or physical injury to animals or other individuals; and 2) twice weekly aggressive outbursts of lesser severity for a period lasting at least 3 months (i.e., outbursts of verbal aggression or outbursts of physical aggression that do not result in damage or destruction of property and do not result in physical injury to animals or other individuals). The corresponding SCID-5 questions start with the more serious types of physical aggression (angry outbursts resulting in someone getting hurt, angry outbursts resulting in an animal getting hurt, and angry outbursts resulting in damage to property) and then go on to inquire about the less serious forms of aggression, including verbal aggression (defined as "temper tantrums, tirades, verbal arguments, or fights") and forms of physical aggression that do not result in injury to others or damage to property. After establishing the presence of these types of aggressive outbursts, the interviewer must then inquire about whether the minimum frequency requirements have been met. For the more severe form, the interviewer asks, "During the past year have you had at least three such outbursts?" For the less severe form, the interviewer asks, "If you were to include all the kinds of angry outbursts that we just talked about in the past year (both verbal and physical), did they altogether ever happen as often as twice a week, on average, for at least 3 months?"

The SCID-5-RV includes ratings for both the more severe and less severe forms of aggressive outbursts to facilitate collection of information about all types of aggressive outbursts for research purposes—even though the ratings for the less severe forms of aggression are theoretically not necessary if criteria are met for the more severe forms of aggression. If the interviewer is interested only if criteria are met for IED, the interviewer may choose to skip directly to the assessment of IED Criterion B (on the top of page Opt-K.3) if a rating of "3" has been given for the first half of Criterion A (i.e., physical aggression causing injury or damage).

Criterion B—Aggressive reactions are grossly out of proportion: The rating of this item should ultimately be based on the judgment of the interviewer, given the subject's recounting of the types of situations that have triggered the aggressive outbursts as compared to the severity of the aggressive outbursts. This is the case even though the follow-up questions ask whether the subject thinks that his or her reactions have been much stronger than they should have been given the circumstances and whether anyone has told him or her that the reaction was way off base given the situation in question.

Criterion C—Recurrent outbursts are not premeditated: The aggressive outbursts in IED are generally impulsive and/or anger-based, rather than premeditated or instrumental. A rating of "1" should be given if all of the outbursts have been "on purpose"—that is, done in order to intimidate someone or force someone to give the subject what he or she wants (e.g., money, power).

Criterion D—Recurrent aggressive outbursts cause clinically significant distress or impairment: As is done throughout the SCID-5 when assessing clinical significance, the interviewer starts by asking an open-

ended question to determine the impact that the recurrent aggressive outbursts have had on the subject's life. The additional follow-up questions are optional and cover various domains of functioning that might be impacted by the aggressive outbursts. These questions should be asked only if it is not clear from the subject's answers whether the outbursts interfered with functioning. Note that several IED-specific impairment questions have been included (e.g., "Has anyone called the police or a supervisor because of these outbursts?" "Have you ever been arrested as a result of your outbursts?" "Have you ever had to pay a lot of money to compensate someone for the damage you caused?").

Criterion F (Part I)—Not better explained by another mental disorder: Many DSM-5 disorders (e.g., Bipolar Disorder) and some personality disorders (e.g., Antisocial Personality Disorder, Borderline Personality Disorder) may have aggressive outbursts as a characteristic or associated feature. According to the DSM-5 text (p. 468), if aggressive outbursts occur only during an episode of another disorder (e.g., Major Depressive Disorder, Bipolar Disorder, PTSD, a psychotic disorder), an additional diagnosis of IED should not be given. (DSM-5 does not list PTSD in its examples of mental disorders to be considered as better explaining the aggressive outbursts in either the IED criteria or the text; however, because PTSD Criterion E1 includes "angry outbursts," PTSD has been added in brackets to the list of disorders in IED Criterion F in the SCID-5.) Regarding the exclusion for Personality Disorders, although the wording of the criterion seems to treat the Personality Disorders the same as other mental disorders, the DSM-5 text (p. 468) does appear to allow IED to be diagnosed in the context of a Personality Disorder if the frequency of the outbursts is greater than is typically seen in these disorders. Similarly, in subjects with a diagnosis of ADHD, an additional diagnosis of IED can be given if the aggressive outbursts are in excess of those usually seen in ADHD and they warrant independent clinical attention (DSM-5, p. 469).

Criterion F (Part II)—Not due to a GMC and not substance/medication-induced): A diagnosis of IED should not be made when aggressive outbursts are judged to result from the physiological effects of a diagnosable GMC (e.g., Alzheimer's disease; brain injury associated with a change in personality characterized by aggressive outbursts; complex partial epilepsy). Nonspecific abnormalities on neurological examination (e.g., "soft signs") and nonspecific electroencephalographic changes are not considered to be "diagnosable medical conditions" and are thus compatible with a diagnosis of IED. Similarly, the diagnosis of IED should not be made when impulsive aggressive outbursts are nearly always associated with intoxication with or withdrawal from substances (e.g., alcohol, phencyclidine, cocaine and other stimulants, barbiturates, inhalants) or if they occur entirely as a side effect of a medication.

11.15.3 Ratings for Current Gambling Disorder (Optional; Opt-K.5–Opt-K.7)

Gambling Disorder is not part of the core SCID-5. If an assessment of current Gambling Disorder is needed, insert pages Opt-K.5 through Opt-K.7 between pages K.7 (the last page of ADHD) and L.1 (the first page of Module L, Trauma and Stressor-Related Disorders), usually after the pages for IED (Opt-K.1–Opt-K.4) if Optional IED is being assessed.

The Screening Module question for Gambling Disorder ("In the past year, have you regularly gone gambling or regularly bought lottery tickets?") is followed up with questions characterizing the kinds of gambling the subject has engaged in and when in the past year the subject has gambled the most in terms of frequency or amount won or lost. Four additional questions are asked in order to determine whether the person's gambling has caused problems and thus warrant an assessment of Gambling Disorder (i.e., "Has your gambling caused you any problems?" "Has anyone objected to your gambling?" "Have you hidden the amount of time or money that you gambled?" "Has your gambling gotten out of

control?"). If there is no evidence suggesting a possible Gambling Disorder in the past year, the interviewer is instructed to skip to the next module.

Criterion A—Persistent and recurrent problematic gambling behavior leading to clinically significant impairment or distress: At least four out of the nine Gambling Disorder items need to have been present during the past 12 months.

Criterion B—Gambling behavior is not better accounted for by a Manic Episode: If problematic gambling occurs only during a Manic Episode, then Gambling Disorder is not diagnosed.

SPECIFIERS FOR GAMBLING DISORDER

SEVERITY SPECIFIERS: The severity of current Gambling Disorder depends on the count of the number of items present in the past 12 months: Mild applies if 4–5 criteria have been met; Moderate if 6–7 criteria have been met; and Severe if 8–9 criteria have been met.

COURSE SPECIFIERS: These specifiers indicate the longer-term course of Gambling Disorder. The Episodic specifier applies if there have been episodes of Gambling Disorder with symptoms subsiding in between, whereas the Persistent specifier applies if the Gambling Disorder has been relatively continuous, lasting for at least several years.

11.16 Module L. Trauma- and Stressor-Related Disorders

In DSM-5, Trauma- and Stressor-Related Disorders are now separate from Anxiety Disorders. Module L includes assessments of Acute Stress Disorder, PTSD, Adjustment Disorder, and Other Specified Trauma- and Stressor-Related Disorder.

11.16.1 Lifetime Trauma History (Core Version; L.1–L.5)

Module L begins with a lifetime trauma history that applies to both Acute Stress Disorder and PTSD. Five screening questions are provided covering major types of trauma: 1) disasters, fires, combat, car and workplace accidents; 2) actual or threatened physical or sexual assault or abuse; 3) seeing another person being physically or sexually assaulted or abused, or threatened with physical or sexual assault; 4) seeing another person killed or dead, or badly hurt; and 5) learning that one of these things happened to someone the subject is close to. In order to capture instances of trauma exposure that might have been missed by these screening questions, an additional question asks whether the subject has ever been a victim of a serious crime. Finally, if the subject has not endorsed any traumatic events thus far, the interviewer concludes the trauma screening by asking the subject to describe the most stressful or traumatic experience ever in his or her life.

If there have been any traumatic events in the past month, the interviewer is instructed to inquire about those events using the detailed questions on page L.2. If there have been events occurring before the past month, the interviewer is asked to review the types of trauma acknowledged by the subject and recorded on page L.1 and then to choose three events to assess in more detail using the questions on pages L.3 through L.5. For each event, the interviewer first records the description of the event and then classifies the event in terms of the type of event (actual or threatened death, actual or threatened serious injury, actual or threatened sexual violence) and the mode of exposure (direct experience, witnessing in person it happening to others, learning about it happening to a close family member or friend, or repeated or extreme exposure to aversive details of traumatic events, corresponding to Criterion A4 for Acute Stress Disorder/PTSD). For each event, the interviewer records the age at the time of the event; and finally, whether it is a single event or prolonged or repeated exposure to the same trauma, such as ongoing domestic violence. The choice of the three events detailed on pages L.3 though L.5 is up to the interviewer and could be the three "worst" events (i.e., most severe), the three most recent events, or any combination.

In the process of deciding whether a traumatic experience qualifies for the Criterion A stressor for either Acute Stress Disorder or PTSD, it is helpful to be aware of the scope of trauma examples that are included in the DSM-5 text (p. 274)—

> Directly experienced [qualifying] traumatic events include, but are not limited to, exposure to war as a combatant or civilian, threatened or actual physical assault (e.g., physical attack, robbery, mugging, childhood physical abuse), threatened or actual sexual violence (e.g., forced sexual penetration, alcohol/drug-facilitated sexual penetration, abusive sexual contact, noncontact sexual abuse, sexual trafficking), being kidnapped, being taken hostage, terrorist attack, torture, incarceration as a prisoner of war, natural or human-made disasters, and severe motor vehicle accidents. For children, sexually violent events may include developmentally inappropriate sexual experiences without physical violence or injury.

Regarding potentially traumatic medical incidents, DSM-5 points out that experiencing a life-threatening or debilitating medical problem does not necessarily qualify. According to DSM-5 (p. 274), "Medical incidents that qualify as traumatic events involve sudden, catastrophic events (e.g., waking during surgery, anaphylactic shock)."

With respect to the types of witnessed events that might qualify, according to DSM-5 (p. 274), such events "include, but are not limited to, observing threatened or serious injury, unnatural death, physical or sexual abuse of another person due to violent assault, domestic violence, accident, war or disaster, or a medical catastrophe in one's child (e.g., a life threatening hemorrhage)." Note that witnessing a natural death, such as being present in a hospital room during the death of a close friend or relative, is not a qualifying trauma. With respect to indirect exposure through learning about an event, according to DSM-5 (pp. 274–275), qualifying traumas are "limited to experiences affecting close relatives or friends and experiences that are violent or accidental (e.g., death due to natural causes does not qualify). Such events include violent personal assault, suicide, serious accident, and serious injury."

Some of these traumatic events may be difficult for a subject to discuss, much less remember the details. If the interviewer notices a subject hesitating or showing other signs of distress, it is important to attend to this difficulty. Often, a subject's discomfort is soothed by hearing why it is important to have details about the traumatic event(s). For example, the interviewer may say, "I know it might be hard for you to describe what happened. It's important for us to get as much detail as we can so that we can link your symptoms to a specific event that happened in your life, so I appreciate you providing the best information you can."

11.16.2 Lifetime Trauma History (Alternative Detailed Version; Alt-L.1–Alt-L.3, L.2–L.5)

For those interested in a more detailed trauma history, an alternative version of the lifetime trauma history is available. (This alternative trauma history is included in Document 12b, the alternative version of Module L, which you would include in your configured SCID in place of Document 12a, the standard version of Module L. In Section 5, "Steps for Customizing the SCID-5-RV for Your Study," see question 5 on p. 21 of this User's Guide for instructions on how to include this alternative version in your configured SCID.) In contrast to the standard version that offers only 5 screening questions, the alternative detailed version provides 28 specific screening questions adapted from the above examples in the DSM-5 text (p. 274), including for example, being in an active war zone, either as military personnel or a civilian; being kidnapped, abducted, or taken hostage; being in a serious car accident; being beaten up, robbed, or mugged; being a victim of sexual violence like a rape or attempted rape; childhood sexual abuse; seeing someone seriously injured or killed; finding out that someone close was murdered, raped, or assaulted; and having had a job that involved being exposed to extremely upsetting things, like collecting human remains, going over crime scenes, or investigating child abuse.

If there have been any traumatic events in the past month, the interviewer is instructed to inquire about those events using the detailed questions on page L.2. If there have been events occurring before the past month, the interviewer is asked to review the types of trauma acknowledged by the subject and recorded on pages Alt-L.1 through Alt-L.3 and then to choose three events to assess in more detail using the questions on pages Alt-L.3 through Alt-L.5. For each event, the interviewer first records the description of the event and then classifies the event in terms of the type of event (actual or threatened death, actual or threatened serious injury, actual or threatened sexual violence) and the mode of exposure (direct experience, witnessing it in person as it happens to others, learning about it happening to a close family member or friend, or repeated or extreme exposure to aversive details of traumatic events, corresponding to Criterion A4 for Acute Stress Disorder/PTSD). Finally, for each event the interviewer indicates the age at the time of the event and whether it was a single event or else prolonged or repeated exposure to the same trauma, such as ongoing domestic violence. The choice of

the three events detailed on pages L.3 through L.5 is up to the interviewer and could be the three "worst" events (i.e., most severe), the three most recent events, or any combination.

11.16.3 Ratings for Current Acute Stress Disorder (L.6–L.10)

A diagnosis of Acute Stress Disorder applies only to exposure to traumas occurring in the past month. If all of the traumatic events have happened before the past month, the interviewer is instructed to skip to the assessment of PTSD.

Criterion A—Exposure to actual or threatened death, serious injury, or sexual violence: If the subject has been exposed to one or more traumatic events in the past month, the interviewer is instructed to review the description of the traumatic events on page L.2 to verify that at least one of these traumatic events meets the requirement of Criterion A. The ratings for the subcomponents of Criterion A, indicating the mode of trauma exposure (directly experiencing, witnessing in person, learning that it happened to a close family member or friend, or experiencing repeated or extreme exposure to aversive details), are usually straightforward because this information should already have been collected in the detailed questioning about events in the past month on page L.2. If the subject has been exposed to more than one qualifying event in the past month, the interviewer determines which event has had the greatest impact on the subject by asking "Which of these do you think has affected you the most in the past month?"

Criterion B—Nine (or more) symptoms from any of the five symptom categories: This criterion simply requires at least 9 (out of the list of 14) symptoms, unlike the PTSD requirements of a certain minimum number of symptoms from each of the four PTSD symptom groups. All of the Acute Stress Disorder Criterion B items are included in the PTSD criteria set except Criterion B6, which is included in the PTSD subtype With Dissociative Symptoms (see Table 5). Please refer to descriptions of the PTSD items in Section 11.16.4, "Ratings for Posttraumatic Stress Disorder," in this User's Guide for more details.

Table 5: Correspondence between Acute Stress Disorder Criterion B and PTSD Criteria items

Acute Stress Disorder Criterion B items	Corresponding PTSD criteria
B1—intrusive memories	B1
B2—distressing dreams	B2
B3—dissociative reactions (flashbacks)	B3
B4—psychological distress or physiological reactions in response to cues	B4 and B5 combined
B5—inability to experience positive emotions	D7
B6—derealization	part of the With Dissociative Symptoms subtype
B7—inability to remember aspect of event	D1
B8—avoiding memories, thoughts, or feelings	C1
B9—avoiding external reminders	C2
B10—sleep disturbances	E6
B11—irritable behavior and angry outbursts	E1
B12—hypervigilance	E3
B13—concentration problems	E5
B14—exaggerated startle response	E4

Criterion C—Duration of response is between 3 days and 1 month: Given that the trauma exposure must have occurred within the past month, this criterion is typically automatically met (except if the trauma exposure has occurred within the past 2 days).

Criterion D—The disturbance causes clinically significant distress or impairment: The interviewer starts by asking an open-ended question to determine the impact that Acute Stress Disorder symptoms have had on the subject's life, as is done throughout the SCID-5 when assessing clinical significance. The additional follow-up questions are optional and specifically cover various domains of functioning that might be impacted by the Acute Stress Disorder symptoms. These questions should be asked only if it is not clear from the subject's answers whether the symptoms interfered with functioning.

Criterion E—Not due to a GMC and not substance/medication-induced and not better explained by Brief Psychotic Disorder: This item instructs the interviewer to consider and rule out a GMC or a substance/medication as an etiological cause of the Acute Stress Disorder symptoms. Many individuals respond to trauma exposure by increasing their use of alcohol or other substances. Therefore, what may appear to be the symptoms of Acute Stress Disorder may in fact be due to the direct effects of the alcohol or other substances. Similarly, if exposure to the traumatic event has also caused head trauma, the person may have developed symptoms of mild traumatic brain injury, some of which (e.g., sensitivity to light or sound, irritability, concentration deficits) may be confused with symptoms of Acute Stress Disorder. Acute Stress Disorder should not be diagnosed if all of the symptoms are a manifestation of a head trauma or other GMC.

Some individuals may respond to a traumatic stressor by developing Brief Psychotic Disorder, which may include symptoms such as emotional turmoil, overwhelming confusion, and rapid shifts from one intense affect to another. If the symptoms in response to the stressor are completely explained by Brief Psychotic Disorder, Acute Stress Disorder should not be diagnosed.

SPECIFIERS FOR ACUTE STRESS DISORDER

WITH PANIC ATTACKS: This specifier should be considered if there has been a history of panic attacks (pages F.1–F.2), criteria for Panic Disorder have never been met (pages F.4–F.5), panic attacks have occurred in the context of the reaction to the traumatic stressor (page F.7), and there has been at least one panic attack during the past month. Note that a 1-month time frame has been added to the SCID-5 as a way of operationalizing this specifier; no time frame or frequency requirement is included in DSM-5.

11.16.4 Ratings for Posttraumatic Stress Disorder (L.11–L.19)

No clustering of symptoms is required in the definition of PTSD, unlike most of the syndromal criteria sets in DSM-5 that require that the symptoms occur together within a specified time frame (e.g., in MDE, 5 items out of 9 within the same 2-week period; in Substance Use Disorder, 2 items out of 11 within the same 12-month period). The only temporal constraints imposed on the criteria for PTSD are that the symptoms must have developed or worsened after the trauma (e.g., Criterion D requires "negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred"), that for most of the items the symptoms are either "recurrent" or "persistent," and that the duration of the disturbance (i.e., symptoms in Criteria B, C, D, and E) is more than 1 month. Thus, the thresholds for each of the polythetic criteria (e.g., for Criterion D, 2 items or more out of 7) are determined by simply counting up the number of items coded "3."

Criterion A—Exposure to actual or threatened death, serious injury, or sexual violence: If the subject has been exposed to one or more traumatic events prior to the past month, the interviewer is instructed to

review the description of the traumatic events on pages L.3 through L.5 to verify that at least one of these traumatic events meets the requirements of Criterion A. The ratings for the subcomponents of Criterion A, indicating the mode of trauma exposure (directly experiencing, witnessing in person, learning that it happened to a close family member or friend, or experiencing repeated or extreme exposure to aversive details), are usually straightforward, because this information should already have been collected in the detailed questioning about the events on pages L.3 through L.5. If the subject has been exposed to more than one qualifying event, the interviewer determines which event has had the greatest impact on the subject by asking "Which of these do you think has affected you the most?" If the response to the selected event does not end up meeting full criteria for PTSD, it is certainly possible that one of the other traumatic events (reported on pages L.3 through L.5) has resulted in PTSD. Therefore, in such a case the interviewer should cycle through the PTSD criteria set again (as many times as needed depending on the number of past qualifying traumas), using one of these other traumatic events as a traumatic stressor.

The remaining items in the PTSD criteria set are each first rated for whether the symptom has occurred during the period of time dating from the exposure to the traumatic event up to the present. Then, for each item rated "3," the interviewer follows up with a question in order to determine whether the symptom was present during the past month (e.g., "Has this also been the case in the past month?").

Criterion B—At least one intrusion symptom: It is important to make sure that the intrusion symptoms developed for the first time after exposure to the traumatic event.

Criterion B1—Involuntary and intrusive distressing memories of event: This item requires that the subject has experienced involuntary and intrusive memories of the event. The memories usually include sensory, emotional, or physiological behavioral components. Intrusive recollections are distinguished from depressive ruminations (which, given the high rates of comorbidity with depression, may also be present) in that they are experienced by the person as involuntary and unwelcome.

Criterion B2—Dreams of the event: The distressing dreams that would qualify for a rating of "3" are not necessarily limited to those that replay the event itself, but would also include dream content or affect that is representative or thematically related to the major threats involved in the traumatic event.

Criterion B3—Dissociative reactions in which the event is reexperienced: The person experiences dissociative states that can last from a few seconds to several hours or even days, during which aspects of the event are relived and the person feels or acts as if the event were occurring at that moment. According to the DSM-5 text (p. 275)—

> Such events occur on a continuum from brief visual or other sensory intrusions about part of the traumatic event without loss of reality orientation, to complete loss of awareness of present surroundings. These episodes, often referred to as "flashbacks," are typically brief but can be associated with prolonged distress and heightened arousal.

Because the term "flashbacks" has entered common parlance, the follow-up question specifically asks the subject whether he or she has experienced flashbacks of the event.

Criteria B4 and B5—Psychological distress or physiological reactions to internal or external cues: These criteria are separated into two items in PTSD, one for intense or prolonged psychological distress and the other for marked physiological reactions. (Note that in the Acute Stress Disorder criteria set, these are included as a single combined criterion involving strong emotional or

physiological reactions to reminders of the trauma.) The SCID-5 introduces the assessment of these items with a single question that first establishes the cause-and-effect relationship between exposure to internal or external cues that symbolize or resemble the traumatic event and the development of an intense and unpleasant emotional or physical response. As noted in the DSM-5 text (p. 275), "The triggering cue could be a physical sensation (e.g., dizziness for survivors of head trauma; rapid heartbeat for a previously traumatized child), particularly for individuals with highly somatic presentations."

If the subject denies having any kind of reaction to reminders of the trauma, both Criterion B4 (psychological distress) and Criterion B5 (physiological reactions) can be rated "1." If the subject acknowledges having had some sort of reaction, then the interviewer inquires whether it was an intense or prolonged emotional reaction or a physical reaction and then rates each item accordingly.

Criterion C—Persistent avoidance of stimuli associated with the event: The diagnosis of PTSD requires persistent avoidance of stimuli associated with the traumatic event. In the context of this criterion, the DSM-5 text (p. 275) defines this persistence as "always or almost always" avoiding such stimuli. Given that Criterion F stipulates more than 1 month in duration for Criteria B, C, D, and E, the SCID-5 requires the avoidance to occur almost all of the time for more than 1 month. It is also important for the interviewer to establish that this avoidance behavior began after the traumatic event occurred (i.e., avoidance associated with preexisting phobias should not count toward the diagnosis of PTSD).

Criterion C1—Avoidance of memories, thoughts or feelings: This item requires that the subject makes deliberate efforts to avoid memories, thoughts, or feelings about or closely associated with the traumatic event. Because memories, thoughts, and feelings are internally generated, the only way to avoid them is to utilize distraction techniques such as keeping oneself busy, playing computer or video games, watching TV, or using drugs or alcohol in order to "numb" oneself.

Criterion C2—Avoidance of external reminders that arouse distressing memories, thoughts, or feelings: The person generally avoids external reminders by going out of his or her way to avoid people, places, activities, objects, situations, or anything else likely to arouse memories, thoughts, or feelings about the event. For example, an individual who was involved in a serious car accident might persistently avoid driving, or a combat veteran might persistently avoid situations in which there are likely to be loud noises.

For some individuals, the need to make deliberate efforts to avoid external reminders may depend on the potential for encountering the reminder in his or her daily life. For example, consider an individual who lives in New York City and drives his car only when he needs to go to the supermarket. After getting into a serious car accident, he avoids driving his car to the supermarket and instead arranges for home delivery of his groceries. From a strict behavioral standpoint, his active avoidance behavior would not be persistent because he deliberately avoids driving only on those occasions when the need to drive arises. However, in the context of this criterion, persistent avoidance is as much attitudinal as behavioral. So even if the individual does not actively avoid a reminder every day as in this example, the avoidance would meet the persistent requirement if the person is persistently *aware* that he or she would not be able to get into a car.

Criterion D—Negative alterations in cognitions and mood: This cluster of symptoms involves negative alterations in cognitions and mood that begin or worsen after the traumatic event occurred. The requirement that the symptoms begin or worsen after the traumatic event is especially important given both the relatively nontrauma-specific nature of several of these symptoms (e.g., persistent negative

emotional state, diminished interest or participation in activities, inability to experience positive emotions) and the fact that some of these items (e.g., persistent and exaggerated negative beliefs or expectations about oneself, others, or the world) may represent preexisting personality traits.

Criterion D1—Inability to remember an important aspect of the event: Given the common co-occurrence of trauma exposure with head trauma and with alcohol and substance use, it is important to ensure that the amnesia is not due to head injury and substance-induced memory loss (e.g., "blackouts") but is instead dissociative in nature.

Criterion D2—Negative beliefs or expectations about oneself, others, or the world: A rating of "3" applies when the persistent and exaggerated negative beliefs about oneself, others, or the world is associated with the traumatic event. This requirement is set forth in the first part of Criterion D (i.e., "Negative alterations in cognitions and mood associated with the traumatic event"), which is established either by virtue of the content of beliefs being somehow related to the traumatic event or by the fact that the beliefs developed only after the trauma exposure. The DSM-5 criteria and text provide several examples of negative beliefs, such as "No one can be trusted," and "The world is completely dangerous." Developing the belief that the world is a completely dangerous place after exposure to a natural disaster or random act of violence suggests that the belief is associated with the trauma and would justify a rating of "3." Having a persistent belief that "no one can be trusted" is much less likely to be associated with these types of trauma and suggests that those beliefs were part of a preexisting belief system. (However, for other types of trauma, such as date or military rape, "no one can be trusted" may be a trauma-associated belief.) As with Criterion C, "persistent" is defined in DSM-5 as "always or almost always," which has been operationalized in the SCID-5 as "almost all of the time for more than 1 month."

Criterion D3—Persistent distorted cognitions about causes or consequences of the traumatic event: This criterion requires the presence of persistent erroneous cognitions about the causes (i.e., who or what was to blame) or consequences (e.g., self-deprecation of oneself for having developed PTSD symptoms) of the traumatic event. Determining whether such cognitions are in fact erroneous can sometimes be challenging without firsthand knowledge about what actually happened. While in some cases the cognitive distortions are obvious (e.g., "It's my fault that my uncle abused me"), in other cases it may be discernable only by virtue of the subject's unreasonable level of certainty about an ambiguous situation (e.g., a veteran's insistence about not acting quickly enough under fire as the primary cause of his platoon being attacked). As with Criterion D2, "persistent" is defined in DSM-5 as "always or almost always," which has been operationalized in the SCID-5 as "almost all of the time for more than 1 month."

Criterion D4—Persistent negative emotional state: Although examples are provided in the criterion to illustrate the "negative emotional state" (i.e., "fear, horror, anger, guilt, or shame"), any negative emotional state would count, including feeling sad, empty, or numb. As with Criterion D2, "persistent" is defined in DSM-5 as "always or almost always," which has been operationalized in the SCID-5 as "almost all of the time for more than 1 month." Given that individuals with chronic negative mood states are at increased risk of developing PTSD when exposed to a traumatic event, it is important to discern that if the person had a persistent negative emotional state before the trauma exposure, it significantly worsened after the trauma.

Criterion D5—Diminished interest or participation in significant activities: There are two components to this criterion (i.e., diminished interest in activities and diminished participation in activities), the presence of either of which would justify a rating of "3." As with Criterion D4, it is especially

important to ensure that the diminished interest or participation in activities represents a change in the person since exposure to the traumatic event.

Criterion D6—Feelings of detachment or estrangement from others: This may be manifested as a general feeling of being disconnected from others or that the person has closed himself or herself off from other people.

Criterion D7—Inability to experience positive emotions: In contrast to the similar item in the DSM-IV PTSD criteria set (i.e., "restricted range of affect"), which suggested a general diminution in emotional responsiveness, only positive expressions of affect are restricted in DSM-5 Criterion D7. It is especially important to ensure that the inability to experience positive feelings represents a change in the person since exposure to the traumatic event.

Criterion E—Marked alterations in arousal and reactivity: At least two of the six listed items must have been present. It is important to establish that the marked alterations in arousal and reactivity are associated with the traumatic event by virtue of the fact that the symptoms began or worsened after the traumatic event occurred.

Criterion E1—Irritable behavior and angry outbursts: This item requires more than just irritable mood; a rating of "3" requires irritable behavior and angry outbursts that are typically manifested as verbal or physical aggression toward people or objects.

Criterion E2—Reckless or self-destructive behavior: According to the DSM-5 text (p. 275), examples of reckless or self-destructive behavior include dangerous driving, excessive alcohol or drug use, or self-injurious or suicidal behavior.

Criterion E3—Hypervigilance: The hypervigilance is manifested as a heightened sensitivity to potential threats, including those that are directly related to the traumatic experience (e.g., after a motor vehicle accident, being especially sensitive to the threat potentially caused by cars or trucks) and those not related to the traumatic event (e.g., being fearful of suffering a heart attack).

Criterion E4—Exaggerated startle response: This is manifested by the person being very reactive to unexpected stimuli, such as loud noises or unexpected movements (e.g., being "jumpy" in response to a telephone ringing).

Criterion E5—Problems with concentration: This may be manifested by difficulty remembering daily events (e.g., forgetting one's telephone number) or attending to focused tasks (e.g., following a conversation for a sustained period of time).

Criterion E6—Sleep disturbances: Most commonly there are problems with sleep onset and maintenance.

Criterion F—Duration is more than 1 month: The minimum duration of symptoms in each of the symptom clusters (i.e., Criterion B, C, D, and E) is more than 1 month.

Criterion G—The disturbance causes clinically significant distress or impairment: The interviewer starts by asking an open-ended question to determine the impact that the PTSD symptoms have had on the subject's life, as is done throughout the SCID-5 when assessing clinical significance. The additional follow-up questions are optional and cover various domains of functioning that might be impacted by

PTSD symptoms. These questions should be asked only if it is not clear from the subject's answers whether the symptoms interfered with functioning.

Criterion H—Not due to a GMC and not substance/medication-induced: This item instructs the interviewer to consider and rule out a GMC or a substance/medication as an etiological cause for the PTSD symptoms. Many individuals respond to trauma exposure by increasing their use of alcohol or other substances. Therefore, what may appear to be the symptoms of PTSD may in fact be due to the direct effects of the alcohol or other substances.

SUBTYPES AND SPECIFIERS FOR POSTTRAUMATIC STRESS DISORDER

WITH DELAYED EXPRESSION*:* This specifier is used to indicate that at least 6 months have elapsed between the event and the time when full criteria for PTSD are first met. It is not required that there be *no* PTSD symptoms at all during the 6 months; most individuals for whom the With Delayed Expression specifier applies will have at least some symptoms during this time period, but not the full syndrome.

WITH DISSOCIATIVE SYMPTOMS/WITHOUT DISSOCIATIVE SYMPTOMS: Two subtypes are offered in the SCID-5 to indicate the presence or absence of persistent or recurrent experiences of depersonalization and/or derealization in the past month. DSM-5 includes only the subtype With Dissociative Symptoms but does not include a corresponding subtype (e.g., "Without Dissociative Symptoms"), which is required according to the DSM-5 convention (p. 21) that subtypes are "mutually exclusive and jointly exhaustive phenomenological subgroupings within a diagnosis." Because of this requirement that subtypes be mutually exclusive and jointly exhaustive, the subtype Without Dissociative Symptoms has been included in the SCID-5.

WITH PANIC ATTACKS: This specifier should be considered if there has been a history of panic attacks (pages F.1–F.2), criteria for Panic Disorder have never been met (pages F.4–F.5), panic attacks have occurred in the context of the reaction to the traumatic stressor (page F.7), and there has been at least one panic attack during the past month. Note that a 1-month time frame has been added to the SCID-5 as a way of operationalizing this specifier; no time frame or frequency requirement is specified in DSM-5.

11.16.5 Ratings for Current Adjustment Disorder (L.20–L.22)

Adjustment Disorder applies to emotional or behavioral symptoms that do not meet criteria for another specific mental disorder (i.e., excluding the Other Specified and Unspecified categories) and that have developed in response to an identified psychosocial stressor. Consequently, Adjustment Disorder has been placed at the very end of the SCID-5, after evaluation of all the other mental disorders. If the interviewer has reached this point in the SCID-5 and there are symptoms that have occurred in the past 6 months that are not accounted for by any of the specific disorders already diagnosed in the SCID (excluding Other Specified and Unspecified categories), then the interviewer should proceed with the evaluation of Adjustment Disorder.

Criterion A—Development of symptoms in response to identifiable stressor: This criterion establishes that the diagnostically unaccounted-for symptoms that led the interviewer to commence the assessment of Adjustment Disorder have developed in response to a stressor. The first question determines whether the stressor was present before the onset of the symptoms. The second question tries to establish whether the symptoms occurred in response to the stressor ("Do you think that [STRESSOR] had anything to do with your developing [SXS]?"). The final question determines whether the onset of the symptoms has been within 3 months of the stressor. For single event stressors, the

focus is on how long it took after the stressor for the symptoms to develop. For chronic stressors that may be ongoing and without a clear end point, the focus is on when the chronic stressor started.

Criterion B—Marked distress that is out of proportion to the severity of stressor or symptoms are clinically significant: This criterion requires either that the individual's distressing symptoms are out of proportion to the severity of the stressors or that the symptoms cause clinically significant distress or impairment. Given the difficulty in determining whether the symptoms are more severe than they should be (i.e., out of proportion to the stressor), the order of the subcomponents to this criterion has been switched so that the more straightforward assessment of impairment comes first; the interviewer only needs to assess the proportionality of the symptoms if there is no clinically significant impairment in functioning.

Criterion C—Does not meet criteria for another mental disorder and is not an exacerbation of a preexisting mental disorder: The two parenthetical questions are geared to assist the interviewer with the assessment of the second part of the item, which excludes exacerbations of preexisting disorders. The first part of the item should automatically be true because of the SCID requirement for proceeding with the evaluation of current Adjustment Disorder.

Criterion D—Does not represent normal bereavement: Because normal bereavement can manifest as a clinically significant symptomatic reaction to a stressor (i.e., loss of a loved one), this criterion is needed to prevent normal grief from being pathologized.

Criterion E—Symptoms do not persist for more than 6 months after stressor or its consequences have terminated: There is a limit of 6 months for the duration of symptoms after the stressor *or its consequences* have terminated for the presentation to be considered consistent with a diagnosis of Adjustment Disorder. However, the broadness of the concept of the "consequences" of the stressor (e.g., a divorce may be followed by ongoing financial struggles) effectively means that there is no time limit for many (if not most) stressors. In such cases, the Chronic specifier should be used to indicate that the duration of the response exceeded 6 months.

SUBTYPES AND SPECIFIERS FOR ADJUSTMENT DISORDER

ADJUSTMENT DISORDER SUBTYPES: Five specified subtypes and one unspecified type are available to indicate the predominant symptoms characterizing the response to the stressor.

ACUTE or CHRONIC SPECIFIER: This specifier is based entirely on the total duration of the disturbance.

11.16.6 Ratings for Other Specified Trauma- and Stressor-Related Disorder (L.23–L.24)

If there are symptoms characteristic of a Trauma- and Stressor-Related Disorder that do not meet criteria for Acute Stress Disorder, PTSD, or Adjustment Disorder, then Other Specified Trauma- and Stressor-Related Disorder should be considered. The paragraph defining this disorder in DSM-5 (p. 289) has been converted into a set of three ratings in the SCID-5.

Symptoms characteristic of a Trauma- and Stressor-Related Disorder: This item indicates that this category is intended for presentations that include reactions to stressors that do not meet the full criteria for Acute Stress Disorder, PTSD, and Adjustment Disorder (diagnosed in Module L).

Symptoms cause clinically significant distress or impairment: This item clarifies that all of the DSM-5 Other Specified categories must meet the basic requirement that the symptoms be sufficiently severe as to have a negative impact on the subject's life.

Indication of the type of symptomatic presentation: The first three examples in DSM-5 of presentations that can be specified using the Other Specified designation (supplemented by two additional SCID-specific examples) are included. For specified trauma- or stressor-related presentations not covered by one of these examples, the Other Specified designation is used, in which case the interviewer should record the specific reason that the criteria for one of the Trauma- and Stressor-Related Disorders were not met. For presentations in which there is insufficient information to make a more specific diagnosis, Unspecified Type should be recorded.

12. TRAINING

Refer to the SCID Web site (www.scid5.org) for the most up-to-date information regarding available training materials, as new materials are continually being developed.

Ideally, training should involve the following sequence:

1. Study Sections 6–9 in this User's Guide, which respectively cover the SCID-5-RV Basic Features, Administration, Conventions and Usage, and DO's and DON'Ts.
2. Carefully read through every word of the sections of the SCID that you are planning to use, making sure that you understand all of the instructions, the questions, and the DSM-5 diagnostic criteria. As you are reading through each module, refer to the corresponding User's Guide section of "Special Instructions for Individual Modules." Review the DSM-5 text sections "Diagnostic Features" and "Differential Diagnosis" for disorders included in the SCID-5.
3. Now practice reading the SCID-5 questions aloud so that eventually it sounds as if SCID is your mother tongue.
4. Try out the SCID-5 with a colleague (or significant other) who can assume the role of a subject. Have them portray a case of someone they know.
5. Watch the didactic video training program SCID-101. Please refer to the SCID Web site (www.scid5.org) for information about the contents of the didactic videos and how to order them.
6. Role-play the cases in Appendix C, "Training Materials," with a colleague. These cases have been designed to take you through the SCID-5 modules, not necessarily to demonstrate your dramatic talent.
7. Watch videos of SCID-5 interviews (which can be ordered from the SCID Web site, www.scid5.org) and make your own ratings as the interviews proceed. Compare your ratings with the "expert" ratings that are included with each video.
8. Try out the SCID-5 on actual subjects who are as representative as possible of those who will be included in your research study. Ideally, these rehearsals should be observed (and co-rated) by someone who has experience administering the SCID, followed by a discussion of the interviewing technique and all sources of disagreement in the ratings.
9. Conduct a series of group SCID sessions in which the SCID-5 is administered by one interviewer while the other SCID interviewers observe and contemporaneously make their own ratings. At the conclusion of the SCID interview, the interviewers go through the SCID and compare ratings, with discussion focusing on those ratings where there are disagreements. These exercises can help to ensure that all of the SCID interviewers are in agreement with respect to their understanding of the DSM-5 diagnostic criteria and SCID methodology. It is recommended that these group SCID sessions be conducted periodically throughout the life of a study in order to minimize rater drift.
10. Consider setting up an on-site SCID-5 training workshop conducted by an associate of the Biometrics Research Department (e-mail: scid5@columbia.edu). On-site SCID training consists primarily of a demonstration of a live SCID interview followed by group supervision of SCID interviews conducted by the trainees on actual subjects. It is expected that the trainees will have watched the SCID-101 didactic training series before the on-site training so that they are prepared to participate in the

group interviews. The training usually begins with a discussion of any issues that have arisen during the didactic portion of the training, followed by a series of SCID interviews conducted on volunteer subjects. Typically the first SCID interview is conducted by the trainer in order to demonstrate his or her SCID technique, followed by interviews conducted by the trainees (one or two trainees per interview, depending on the number of people being trained and the duration of the training).

11. If multiple raters will be administering the SCID, it is important to implement procedures to ensure diagnostic agreement among the raters. Ideally you should try to 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 the most from such a study if you record the interviews either on video or audio, then have each interviewer review and rate the other interviewer. This should be followed by a discussion of any sources of disagreement. Alternatively, you can conduct a joint reliability study where SCID interviews conducted by one interviewer are observed by the other interviewers who independently make their own ratings. Although a joint reliability design is a less rigorous procedure for assessing reliability, the practical limitations of getting subjects to agree to repeated SCID interviews often necessitate this type of design. You will need to make a series of audio or video recordings conducted by the interviewers, suspending the skip-outs for all the diagnoses that are of interest, and have all the interviewers rate each recording. 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 10 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 could end up with at least five cases of Panic Disorder and five cases of Generalized Anxiety Disorder. Note that SCID-5 results from subjects recruited for participation in the reliability study can potentially be used for the actual study you are conducting (i.e., you do not have to "waste" precious subjects for the reliability study), as long as you reach a group consensus about the SCID ratings.

12. Another way to ensure that the SCID interviewers are administering the SCID properly is to record the interviewers and then send the recordings (plus the accompanying rated SCIDs) to Biometrics Research for review and critique. Refer to the SCID Web site for more information about how to use this service and its costs.

13. The more of the above-listed training steps you complete, the more skilled the SCID interviewers will become. Before letting a new trainee start doing SCID-5 interviews and scoring for an actual study, it is advisable to evaluate the trainee's ability to administer the SCID properly. This is best done by someone at your site with SCID experience. Appendix D of the SCID-5-RV User's Guide include a SCID evaluation form that indicates the various areas of proficiency that are required to be demonstrated by raters (e.g., "Obtained enough information to make judgments on each item" and "Helped rambling subject to focus on the issue under consideration"). Alternatively, you can record the trainee's interview and send the recording to us for review and critique (see step 12 above). When evaluating the trainee's SCID skills, you should focus on those diagnoses that are most critical for the study (e.g., for an interviewer in a study of anxiety and depression, it may not be very important to deal with the nuances of the differential diagnosis between Schizophrenia and Schizoaffective

Disorder). The most important issue is how competent the interviewer is with subjects similar to those who will be assessed in the study.

14. It is advisable to develop a method for ensuring the ongoing quality of raters over the course of a study. One such program is the Research Triangle Institute (RTI) International's ongoing clinical interviewer training and supervision program. It was developed for the calibration of SCID interviewers in the National Survey on Drug Use and Health Mental Health Surveillance Study (Colpe et al. 2010). Across 5 years of data collection, interrater reliability (IRR) exercises were conducted at the end of each calendar quarter to ensure the quality of the data being collected in the clinical interviews by comparing clinical interviewer (CI) ratings with clinical supervisor (CS) consensus ratings. This allowed for the ongoing evaluation of the diagnostic skills of the CIs and provided retraining for the CIs in order to reduce error in data collected in future quarters.

    Clinical interviews used for these IRR exercises were selected from the pool of recorded interviews conducted for data collection during the calendar year. CSs and CIs listened to the audio file from the selected interview and independently rated the assessed symptoms (e.g., present, absent, subthreshold, or not enough information) and disorders (e.g., present, absent, or not enough information). Having reviewed and rated each interview independently, the CSs met as a group and developed consensus ratings of the symptoms and disorders that became the key for comparison with the CI ratings. For each CI, the total percentage of agreement between his or her ratings and the CS consensus ratings across all symptoms and disorders were calculated.

    In between IRR exercises, the CSs and CIs also participated in group conference calls to calibrate the CIs' ratings to the CSs' consensus ratings. Before these conference calls, CIs were sent an electronic copy of their scored IRR rating sheet that listed their ratings compared with the CSs' consensus ratings and their overall percentages of agreement. The calibration conference calls lasted approximately 1 hour per case and included a review of all symptoms that were assessed, with particular attention devoted to symptoms for which there was disagreement.

    An ongoing training and quality assurance program, such as the one in place at the UCLA Intervention Research Center for Major Mental Illness (Ventura et al. 1998), has demonstrated that a high level of reliability (e.g., kappa values of at least .75 on symptoms, and 90% accuracy in diagnosis) can be maintained even as interviewers leave and new interviewers are trained. For more on SCID reliability, please see Section 13, "Psychometric Issues," in this User's Guide.

13. PSYCHOMETRIC ISSUES

13.1 SCID Reliability

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 for categorical constructs, such as the DSM diagnoses being assessed by the SCID, are usually reported with a statistic called *kappa* that takes into account agreement due to chance (Spitzer et al. 1967). Kappa values above .70 are considered to reflect good agreement; values from .50 to .70, fair agreement; and below .50, poor agreement (Landis and Koch 1977). 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.

Table 6 provides a summary of selected published reliability studies of previous SCID versions. (Refer to the SCID Web site for the most up-to-date list of SCID reliability studies, including the reliability of the SCID-5 as it becomes available). Three studies have examined the reliability of the SCID for DSM-IV. Lobbestael and colleagues (2011) examined the reliability of the Dutch version of the SCID. In a mixed sample of 151 inpatients and outpatients during a joint reliability study, the first rater recorded his or her SCID interview, which was then rated by a second interviewer blind to the first rater's scores and diagnoses. Zanarini and colleagues (2000) examined both joint and test-retest reliability of the SCID as part of the Collaborative Longitudinal Personality Disorders Study. In their study, 84 pairs of raters viewed videotaped SCID interviews for the joint interrater component, and interviewers conducted independent interviews on 52 subjects 7–10 days apart for the test-retest component. Martin and colleagues (2000) examined the reliability of alcohol and other substance use disorders in 71 adolescents using a joint interrater design (two interviewers made independent ratings during the same live SCID interview).

Zanarini and Frankenburg (2001) examined the reliability of the SCID for DSM-III-R using four different methods: interrater reliability of 45 inpatients using conjoint interviews, test-retest reliability of 30 subjects with a 7–10 day time interval between interviews, interrater reliability of 48 patients at their 2- or 4-year follow-up assessment using conjoint interviews, and interrater reliability at time of longitudinal follow-up using 36 videotaped interviews that were made during the initial evaluation phase. In the most extensive reliability study of the SCID, Williams and colleagues (1992) examined multisite test-retest reliability in 592 patients who were a mixture of inpatients, outpatients, patients with substance use issues, and patients selected from the community. Skre and colleagues (1991) determined the interrater reliability of the SCID for DSM-III-R by having three raters independently rate 54 videotaped SCID interviews.

As can be seen immediately in Table 6, the range of kappa values from different studies and for different diagnoses is enormous. Many factors influence the reliability of an interview instrument such as the SCID. We will address some of these below.

Joint Interviews Versus Test-Retest Design: In some studies, a subject is interviewed by one clinician while others observe (either in person or by reviewing a tape) and then make independent ratings ("joint"). Joint interviews produce the highest reliability because all raters are hearing exactly the same story, and because the trail of skip instructions provides clues to the observers about the ratings made by the interviewer. A more stringent test of reliability (test-retest, also called *reliability* based on

independent interviews) entails having the same subject interviewed at two different times by two different interviewers. This method tends to lead to lower levels of reliability because the subject may, even when prompted with the same questions, tell different stories to the two interviewers ("information variance"), resulting in divergent ratings.

Interviewer Training: Raters who are well trained, and particularly, raters who train and work together are likely to have better agreement on ratings. It is worth noting that the professional discipline of the interviewer (e.g., psychiatrist, psychologist, social worker) does not appear to contribute to differences in reliability.

Subject Population: Subjects with the most severe and florid psychiatric disorders (e.g., patients repeatedly hospitalized with Schizophrenia or Bipolar Disorder) are likely to yield more reliable SCID diagnoses than subjects with milder psychiatric conditions that border on normality. This reflects the fact that relatively minor diagnostic disagreements are more likely to have a profound effect when the severity of the disorder is just at the diagnostic threshold. For example, a disagreement about a single criterion for a subject with exactly five out of nine symptoms of an MDE can make the difference between having a diagnosis of Major Depressive Disorder or Unspecified Depressive Disorder, whereas a one-item disagreement for a subject with seven out of nine items would probably not result in any apparent disagreement on the diagnosis.

Disorder Base Rates: The base rates of the diagnoses in the population being studied affect the reported reliability. If the error of measurement for a diagnostic instrument is constant, reliability varies directly with the base rates. It is thus harder to obtain good reliability for a rare diagnosis than for a common diagnosis. For example, SCID reliability for Major Depressive Disorder will be higher in a mood disorders clinic than in a community sample, in which the base rate of Major Depressive Disorder is much lower.

Table 6: Selected SCID-I[a] Reliability Studies

Reference	Lobbe-stael et al. 2011	Zana-rini et al. 2000	Zana-rini et al. 2000	Martin et. al. 2000	Zana-rini and Frank-enburg 2001	Zana-rini and Frank-enburg 2001	Zana-rini and Frank-enburg 2001	Zana-rini and Frank-enburg 2001	Williams et al. 1992	Skre et al. 1991
Population Studied	*N* = 151 (mixed inpt./ outpt.)	*N* = 27 (video-tape sample)	*N* = 52 (test-retest sample)	*N* = 71 (outpt. ado-lescent alcohol users)	*N* = 30	*N* = 45 (inpt.)	*N* = 48	*N* = 30	*N* = 592; (mixed inpt., outpt, nonpt.)	*N* = 54
Version of SCID	DSM-IV	DSM-IV	DSM-IV	DSM-IV	DSM-III-R	DSM-III-R	DSM-III-R	DSM-III-R	DSM-III-R	DSM-III-R
Design of Reliability Study	Joint; audio-tape	Joint; 84 rater-pairs from 4 sites	7–10 day interval test-retest	Joint; ob-served live	7–10 day interval test-retest	Joint; ob-served live	Joint; ob-served live	Joint; audio-tape	1–3 week interval test-retest	Joint; audio-tape
Major Depressive Disorder	.66	.80	.61		.73	.90	.93	1.0	.64	.93
Dysthymic Disorder	.81	.76	.35		.60	.91	.93	.84	.40	.88
Bipolar Disorder									.84	.79
Schizophrenia									.65	.94
Alcohol Dependence/ Abuse	.65	1.0	.77	.94		1.0			.75	.96
Other Substance Dependence/Abuse	.77	1.0	.76	.94	.77	.95			.84	.85
Panic Disorder	.67	.65	.65		.82	.88			.58	.88
Social Phobia	.83	.63	.59		.53	.86	.71	1.0	.47	.72
Obsessive-Compulsive Disorder	.65	.57	.60		.42	.70			.59	.40
Generalized Anxiety Disorder	.75	.63	.44		.63	.73			.56	.95
Posttraumatic Stress Disorder	.77	.88	.78		1.0	1.0	1.0	1.0		.77
Any Somatoform Disorder										–.03
Any Eating Disorder	.61	.77	.64							
Agoraphobia	.60									
Specific Phobia	.83									

[a]SCID-I = Structured Clinical Interview for DSM Axis I Disorders.

13.2 SCID Validity

The validity of a diagnostic assessment technique is generally measured by determining 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 because structured interviews have been specifically designed to improve on the inherent limitations of an unstructured clinical interview. In fact, a number of studies have used the SCID as the gold standard in determining the accuracy of clinical diagnoses (Fennig et al. 1994a; Kashner et al. 2003; Ramirez Basco et al. 2000; Shear et al. 2000; Steiner et al. 1995).

Perhaps the most accepted (albeit flawed) standard used in psychiatric diagnostic studies is known as a "best estimate diagnosis." Spitzer proposed an operationalization of this best estimate diagnosis, which he termed the "LEAD standard" (Spitzer 1983). This standard involves conducting a longitudinal assessment (L) (i.e., relying on data collected over time), done by expert diagnosticians (E), using all data (AD) that are available about the subjects, such as family informants, review of medical records, and observations of clinical staff. Although conceptually the LEAD standard is appealing, the difficulty in implementing it accounts for its limited use. Several studies (Fennig et al. 1994b, 1996; Kranzler et al. 1995, 1996; Ramirez Basco et al. 2000) used approximations of the LEAD procedure. Both demonstrated superior validity of the SCID over standard clinical interviews at intake episode.

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APPENDIX A: OVERVIEW OF CHANGES IN THE SCID-5-RV

Refer to the SCID Web site (www.scid5.org) for a detailed recounting of the specific changes made in the SCID as a consequence of changes to DSM-5. The major changes in the SCID-5 are summarized below.

Core Versus Enhanced SCID: A number of new disorders have been added to the SCID-5. To try to reduce the length and complexity of the SCID, two versions of the SCID-5 are available: 1) a standard core SCID and 2) an enhanced SCID that includes everything that is in the core SCID, as well as the optional disorders. See Tables 1 and 2 in Section 4, "Diagnostic Coverage of Core and Enhanced Versions of the SCID-5-RV," for a listing of disorders respectively included in the core and enhanced SCID-5.

Changes to the Organization and Diagnostic Coverage of the SCID-5: The SCID-5-RV contains 12 modules that mirror the new organizational structure of the DSM-5.

- Modules A–D (Mood and Psychotic Disorders) and Module E (Substance Use Disorders) cover roughly the same disorders as in the DSM-IV SCID with the exception of the addition of some new disorders (i.e., Cyclothymic Disorder, Past Persistent Depressive Disorder, Premenstrual Dysphoric Disorder) and specifiers (i.e., With Anxious Distress, With Mixed Features).
- Module F (Anxiety Disorders) parallels the new, smaller Anxiety Disorders diagnostic class in DSM-5 and includes Panic Disorder, the phobias (Agoraphobia, Specific Phobia, and Social Anxiety Disorder), and Generalized Anxiety Disorder in the core SCID and an optional assessment of Separation Anxiety Disorder in the enhanced SCID.
- Module G, created to correspond to the new DSM-5 grouping for Obsessive-Compulsive and Related Disorders, includes OCD in the core SCID and four optional disorders—Hoarding Disorder, Body Dysmorphic Disorder, Trichotillomania (Hair-Pulling Disorder), and Excoriation (Skin-Picking) Disorder—in the enhanced SCID.
- Module H is completely new in the SCID and is entirely optional. It includes three Sleep-Wake Disorders: Insomnia Disorder, Hypersomnolence Disorder, and Substance/Medication-Induced Sleep Disorder.
- Module I (now called Feeding and Eating Disorders to correspond to the DSM-5 diagnostic class) includes Anorexia Nervosa, Bulimia Nervosa, and Binge-Eating Disorder in the core SCID, and the optional Avoidant/Restrictive Food Intake Disorder in the enhanced SCID.
- Module J (Somatic Symptom and Related Disorders, corresponding to the DSM-IV Somatoform Disorders) is also entirely optional and includes Somatic Symptom Disorder and Illness Anxiety Disorder.
- Module K (Externalizing Disorders, which does not correspond to any single DSM-5 diagnostic class) includes Adult Attention-Deficit/Hyperactivity Disorder in the core SCID and two optional disorders, Intermittent Explosive Disorder and Gambling Disorder, in the enhanced version.
- Module L (Trauma- and Stressor-Related Disorders) includes Acute Stress Disorder, PTSD, and Adjustment Disorder, all in the core SCID.

Changes to the Chronology Sections: Another significant change in the SCID-5 is the greater attention paid to determining whether or not full criteria are *currently* met for the disorders. The assessment of most of the disorders in the DSM-IV SCID, especially the Anxiety Disorders, focused on determining the *lifetime* presence of each disorder by using questions such as "Have you ever been very anxious about or afraid of (PHOBIC SITUATIONS)?" Once it was determined that full criteria had been met on a lifetime basis, whether or not criteria were currently met was determined by simply asking the subject a single general question about the disorder [in the case of Agoraphobia, "During the past month, have you avoided (PHOBIC SITUATIONS)?"]. While this worked as a rough approximation of whether the disorder was also current, it fell far short of actually documenting whether the full criteria were currently met, the determination of which can be important for selecting proper treatment, determining current prevalence rates, or documenting whether the subject meets the inclusion and exclusion criteria for a clinical trial.

The SCID-5 includes a more detailed and rigorous assessment of whether the full criteria are currently met in order to address this shortcoming. Three methods have been adopted for doing this, depending on the type of criteria set.

1) "Current" is assessed after lifetime. After completing the initial lifetime assessment, the interviewer then determines whether the disorder is "current." This is similar to the approach used throughout the SCID for DSM-IV. The difference in the SCID-5 is that the interviewer actually verifies that certain critical diagnostic criteria (e.g., those requiring persistence and distress or impairment) are met during the current time period.
2) Lifetime is assessed after "current." For some disorders, whether the criteria are currently met is determined first, and lifetime occurrence is then determined only if criteria are not currently met. This is the approach used in the DSM-IV SCID for mood episodes. In the SCID-5, its use has been expanded to include past episodes of Persistent Depressive Disorder, and Generalized Anxiety Disorder, and has been adopted for the assessment of Substance Use Disorders.
3) Lifetime and "current" are assessed in tandem. Finally, for some criteria sets (like Eating Disorders and PTSD), for each criterion rated "3" for lifetime, the interviewer then determines whether or not the criterion has been met for the current time period.

The time frame for what constitutes "current" in the SCID-5 differs from prior editions of the SCID, in which most disorders were considered to be current if criteria were met for any time during the past month. (Notable exceptions were current Dysthymic Disorder, which had a 2-year time frame and current Generalized Anxiety Disorder, with a 6-month time frame). For the SCID-5, the time frame for current varies much more widely across the various disorders and is determined by the duration and symptom clustering requirements set forth in the DSM-5 criteria. For example, PTSD has a required minimum duration of more than 1 month and uses the past month as the current time frame; whereas Agoraphobia, Social Anxiety Disorder, and Specific Phobia use the past 6 months, given that each of these disorders requires persistence over a 6-month period. Because the symptom-clustering time frame in Substance Use Disorders is at least two items over a 12-month period, the prior 12 months is used as the current time frame for Substance Use Disorders.

Specifiers for the DSM-5 disorders (including severity) are applicable in the SCID-5 only when the disorder is considered to be current. DSM-5 offers severity and remission specifiers for only certain disorders, unlike DSM-IV, which offered Mild, Moderate, Severe, In Partial Remission, and In Full Remission specifiers for every disorder. The dimensional severity ratings for Schizophrenia Spectrum and Other Psychotic Disorders included in DSM-5 Section III ("Emerging Measures and Models") have been

incorporated into the SCID-5 Module B (Psychotic Symptoms); however, none of the other dimensional severity measures in Section III are included.

Changes to Other Specified (formerly "NOS") Conditions: The SCID-5 includes the DSM-5 Other Specified Disorder categories for situations in which none of the specific DSM-5 categories is appropriate. The SCID requires the interviewer to indicate the specific reason for using the residual category, as is the case with DSM-5. Some new Other Specified categories have been added to DSM-5 (and thus the SCID-5) that were not included in the DSM-IV SCID: Other Specified Obsessive-Compulsive and Related Disorder, Other Specified Feeding or Eating Disorder, and Other Specified Trauma- and Stressor-Related Disorder.

Patient Edition and Nonpatient Edition: Unlike previous SCID versions, the SCID-5-RV no longer has separate designated "editions" for use with patients (SCID-P) or nonpatients (SCID-NP). These two editions of the DSM-IV SCID differed only with respect to which version of the Overview was used. For the SCID-5, the appropriate version of the Overview (i.e., Patient Version or Nonpatient Version) is used when configuring the modules.

Changes to the Overview: One significant change is that the screening for drugs and alcohol now takes place in the Overview section, rather than in Module E (Substance Use Disorders). This allows the interviewer to become familiar with the subject's drug history in advance of assessing the Mood and Psychotic modules. This earlier screening facilitates the determination of whether mood or psychotic symptoms are primary, due to a GMC, or substance-induced.

Questions have been added to the Overview to assess lifetime suicidal ideation and behavior, as well as current (past week) ideation or behavior. These questions are not intended to substitute for the use of a suicide rating scale to make a more quantified determination of suicide risk. Instead, they are intended to uncover past episodes of psychopathology and treatment, as well as provide important information to help the clinician determine current suicide risk (and the possible need for immediate intervention).

***Changes to the Screening Module*:** Two versions of the Screening Module are available. The standard version (with 15 questions) screens for only the core SCID disorders, whereas the enhanced version (30 questions) includes screening questions for both the core and optional disorders. Consequently, the screening questions are now contained in a separate module from the Overview, in order to allow the interviewer to select the appropriate Screening Module. Note also that separate screening questions are provided for current and past Generalized Anxiety Disorder. PTSD, Acute Stress Disorder, and Adjustment Disorder continue not to have screening questions in the Overview.

Changes to Module A (Mood Disorders): The major change in the SCID assessment of current and past MDEs stems from the elimination in DSM-5 of the bereavement exclusion (i.e., that the disturbance is not better accounted for by bereavement) and its replacement with a note recommending the exercise of clinical judgment in situations in which the MDE occurs in the context of a significant loss. Because of a lack of clear instructions in guiding the interviewer how to reliably make this judgment, this note has not been implemented in the SCID-5; thus, a diagnosis of MDE is given regardless of context.

For current MDE, two new specifiers added to DSM-5 are included in the SCID-5: With Anxious Distress and With Mixed Features. Similarly, the assessments of current Manic Episode and current Hypomanic Episode are also followed by assessments of the With Anxious Distress and With Mixed Features specifiers.

The SCID assessment of Persistent Depressive Disorder (formerly Dysthymic Disorder) has been greatly simplified by the elimination of the DSM-IV exclusion of an MDE during the first 2 years of the disturbance. The SCID-5 now assesses both current and past Persistent Depressive Disorder, with past Persistent Depressive Disorder being assessed only if criteria are not met for current. An assessment for current Premenstrual Dysphoric Disorder, which is new to DSM-5, has been added to the SCID-5. Premenstrual Dysphoric Disorder requires a 12-month duration; hence, the SCID assessment uses the past 12 months as the current time frame.

Finally, DSM-5 no longer has categories for Mood Disorder Due to Another Medical Condition and Substance/Medication-Induced Mood Disorder, in keeping with the splitting of the DSM-IV Mood Disorders grouping into Bipolar Disorders and Depressive Disorders in DSM-5. Instead, there are now separate diagnoses for Bipolar Disorder Due to Another Medical Condition and Depressive Disorder Due to Another Medical Condition, and Substance/Medication-Induced Bipolar Disorder and Substance/ Medication-Induced Depressive Disorder.

Changes to Module B and Module C (Psychotic Symptoms and Disorders): For Module B (as well as for the Psychotic Screening Module B/C), separate ratings, SCID questions, and definitions have been added for religious delusions, delusions of guilt, jealous delusions, and erotomanic delusions. Similarly, separate ratings are now made for olfactory and gustatory hallucinations.

The DSM-5 severity ratings for delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, and negative symptoms during the prior 7 days are included in Module B in keeping with the DSM-5 recommendation that the past 7 days be used to rate current severity in each of the Psychotic Disorders. These components of psychosis replace the Schizophrenia subtypes, which have been eliminated in DSM-5.

Changes to Module E (Substance Use Disorders): The elimination of the DSM-IV distinction between Dependence and Abuse has resulted in a simplification of this module. There are now only one 11-item Alcohol Use Disorder criteria set and one 11-item Nonalcohol Substance Use Disorder criteria set to evaluate. However, the SCID-5 first assesses current Alcohol or Substance Use Disorder (defined as having symptoms that meet criteria in the past 12 months) and, if criteria are not met, then assesses whether criteria have been met for any 12-month period before the past 12 months.

The drug classes have been reorganized in DSM-5 and thus the SCID-5. There is no longer a separate drug class for cocaine in DSM-5 (it is included within the Stimulants grouping); Hallucinogens and Phencyclidine have been separated in the SCID-5 into two drug classes (they are combined in DSM-5), and Inhalants are now in their own drug class in the SCID-5. Given the elimination of Polysubstance Dependence in DSM-5, that drug use diagnosis has been eliminated from the SCID-5 as well.

Because of the complexity of the dependence/abuse assessment in the DSM-IV SCID, two versions of this module were offered: a standard version, in which the interviewer determined whether criteria were met for dependence/abuse on any drug class (starting with the class used most heavily), and an alternative version that allowed for the simultaneous rating of Substance Use Disorders for every drug class that the subject had ever used above a certain threshold. For the SCID-5, there is now only one version of Module E, but it has been modified for more flexible use so that the interviewer can decide how many different drug classes to assess. The interviewer is thus asked to choose from one of three options for assessment. Option #1 (which corresponds to the standard method in the DSM-IV SCID)

involves first assessing the drug class most heavily used. If criteria are met for a Substance Use Disorder, the assessment ends. If not, the interviewer is asked to go successively through drug classes until criteria are met for one of the drug classes. In Option #2, the interviewer assesses Substance Use Disorder for the top three drug classes. In Option #3 (equivalent to the "alternative" approach in the SCID-4), the interviewer assesses the criteria for all drug classes that have ever been used above a threshold of six times in a 12-month period.

Changes to Module F (Anxiety Disorders): To accommodate the inclusion of the specifier With Panic Attacks (which can be applied to any DSM-5 disorder), this module begins by assessing the lifetime presence of panic attacks regardless of whether they are expected or unexpected. In cases in which there have not been at least two recurrent unexpected panic attacks (which qualifies for Panic Disorder), the interviewer notes the context in which the panic attacks have occurred (e.g., during separation from attachment figures). This is done so that the With Panic Attacks specifier can be used later on in the SCID when the corresponding disorder is diagnosed (e.g., PTSD With Panic Attacks).

Other changes in this module include separate assessments of Panic Disorder and Agoraphobia (now distinct disorders in DSM-5) and adding an assessment for past Generalized Anxiety Disorder, which is completed only if criteria are not met for current Generalized Anxiety Disorder. An optional assessment of current Separation Anxiety Disorder is also available.

Changes to Module G (Obsessive-Compulsive and Related Disorders): The assessment of OCD now begins with three separate screening questions designed to screen for the various types of obsessions experienced by patients (i.e., thoughts, images, and urges). Level of insight is also assessed for OCD, Hoarding Disorder, and Body Dysmorphic Disorder in the form of a specifier. Optional assessments of Hoarding Disorder, Trichotillomania, and Excoriation Disorder are now available. The assessment of Body Dysmorphic Disorder, which was included within the Somatoform Disorders Module of the SCID-4, is available as an optional assessment in this module as well.

New Module H (Sleep-Wake Disorders): This optional module assesses current Insomnia Disorder and Hypersomnolence Disorder, as well as Substance/Medication-Induced Sleep Disorder. Insomnia Disorder and Hypersomnolence Disorder require a 3-month duration; hence, the SCID-5 assessment uses the past 3 months as the current time frame. Note that both of these Sleep-Wake Disorders include a criterion that excludes the diagnosis if the sleep disturbance is better explained by, or occurs exclusively during, the course of another sleep-wake disorder (e.g., Narcolepsy, Breathing-Related Sleep Disorders; see Criterion F in Insomnia Disorder and Criterion D in Hypersomnolence Disorder). Given that such information may require an evaluation by a sleep specialist (e.g., using polysomnography), the interviewer is given the option of making a provisional diagnosis of Insomnia Disorder or Hypersomnolence Disorder, and to make a definite diagnosis only if such information is available.

Changes to Module I (Feeding and Eating Disorders): he time frame for current Anorexia Nervosa, Bulimia Nervosa, and Binge-Eating Disorder has been changed to 3 months. An optional assessment of Avoidant/Restrictive Food Intake Disorder is now available.

Changes to Module J (Somatic Symptom and Related Disorders): This optional module replaces the DSM-IV SCID module for Somatoform Disorders and now covers current Somatic Symptom Disorder and Illness Anxiety Disorder. As with the Somatoform Disorders in the DSM-IV SCID, these are diagnosed for the current period (i.e., past 6 months) only.

New Module K (Externalizing Disorders): This module includes Adult ADHD (past 6 months) and, optionally, Intermittent Explosive Disorder (past 12 months) and Gambling Disorder (past 12 months), all new to the SCID-5. Because these are drawn from three different DSM-5 diagnostic classes (i.e., Neurodevelopmental Disorders; Disruptive, Impulse-Control, and Conduct Disorders; Substance-Related and Addictive Disorders), they have been grouped together in the SCID-5 under the rubric Externalizing Disorders.

Changes to Module L (Trauma- and Stressor-Related Disorders): Several changes have been made to the assessment of exposure to traumatic events (Criterion A). The wordy and complicated initial question that was used in the DSM-IV SCID to query subjects about past trauma exposure has been broken down in the SCID-5 into a series of 6 shorter questions that cover a broader range of traumatic events. Moreover, a more detailed alternative trauma history assessment is available for studies that require a greater level of detail. It includes 28 interview questions and ratings for various types of trauma (adapted from the DSM-5 text for PTSD). The assessment of Acute Stress Disorder, which was included in the Optional Module J in the DSM-IV SCID, has been integrated into the SCID-5 trauma assessment. After determining which qualifying trauma items in Criterion A have affected the person the most, the interviewer proceeds with the Acute Stress Disorder assessment if the trauma exposure was in the past month and with the PTSD assessment if the exposure was before the past month. The SCID-5 now concludes this module with an opportunity to assess Other Specified Trauma- and Stressor-Related Disorder for trauma or stressor-related presentations that do not meet the criteria for PTSD, Acute Stress Disorder, or Adjustment Disorder.

APPENDIX B: GUIDELINES FOR CUSTOMIZING THE SCID-5-RV FOR PARTICULAR STUDIES

One of the main features of the SCID-5-RV is its flexibility in terms of allowing the user to make modifications to tailor the interview for a particular study. This appendix reviews the most common types of modifications and provides guidelines for how to make them.

1. Eliminating Disorders That Are Not of Interest

One of the most common reasons to customize the SCID is to remove diagnoses for the sake of efficiency that are not of interest to the study. To facilitate this, the SCID is divided into separate free-standing modules for each class of diagnoses, allowing individual sections of the SCID to be removed without impacting the skip instructions. This type of modification is easily accomplished with the PDF versions of the SCID files and involves simply not including those modules that are not of interest in the final assembled SCID. For example, in a study in which only Mood, Psychotic, and Substance Use Disorders are being assessed, SCID modules F, G, H, I, J, K, and L may be eliminated. Note that because 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, C (or B/C), and D must be used together.

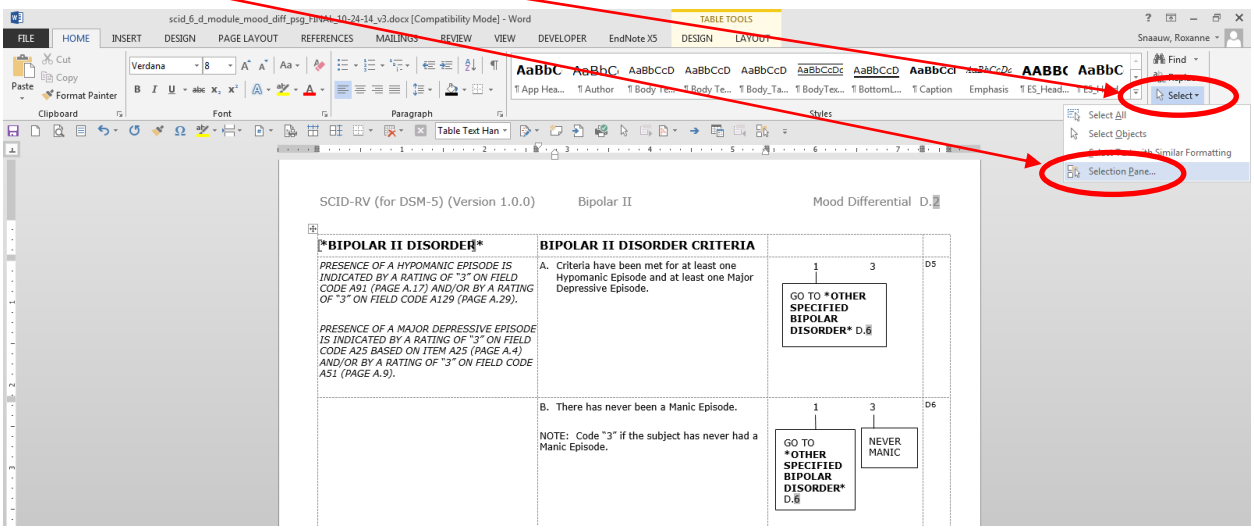
Modifications to the SCID that involve removing the assessments of disorders or subtypes within a SCID module almost invariably require alterations in the skip instructions to accommodate the changes in page numbering that result from the elimination of specific pages. To facilitate making such modifications, the SCID documents are available as MS Word document files that can be modified by the user. For example, let's say an investigator wants to assess subjects for a current Major Depressive Episode but may not be interested in whether there have been any lifetime episodes (i.e., if criteria are not met for a current Major Depressive Episode, the diagnostic flow would skip to current Manic Episode instead of Past Major Depressive Episode). In this case the SCID would be modified by deleting the assessment of PAST MAJOR DEPRESSIVE EPISODE, which would involve removing pages A.5 through A.9 from the SCID, and replacing all of the "GO TO ***PAST MAJOR DEPRESSIVE EPISODE,*** A.5" statements with "GO TO ***CURRENT MANIC EPISODE,*** Page A.5." (Note that the page reference for Current Manic Episode was page A.10 in the standard SCID, which becomes page A.5 in the modified SCID, reflecting the removal of the original pages A.5–A.9.)

Note that in order to make any changes to the graphical elements in the SCID (including lines, arrows, boxes, and the text within the boxes), you need to be familiar with how to use an MS Word feature called the "drawing canvas," because that feature was used in the original creation of all the graphical elements in the SCID-5-RV. (Note: The drawing canvas feature in MS Word that was used to create the SCID document files does not seem to work properly on a Mac computer. A Mac version of the SCID MS Word document files with the drawing canvas feature removed is available.)

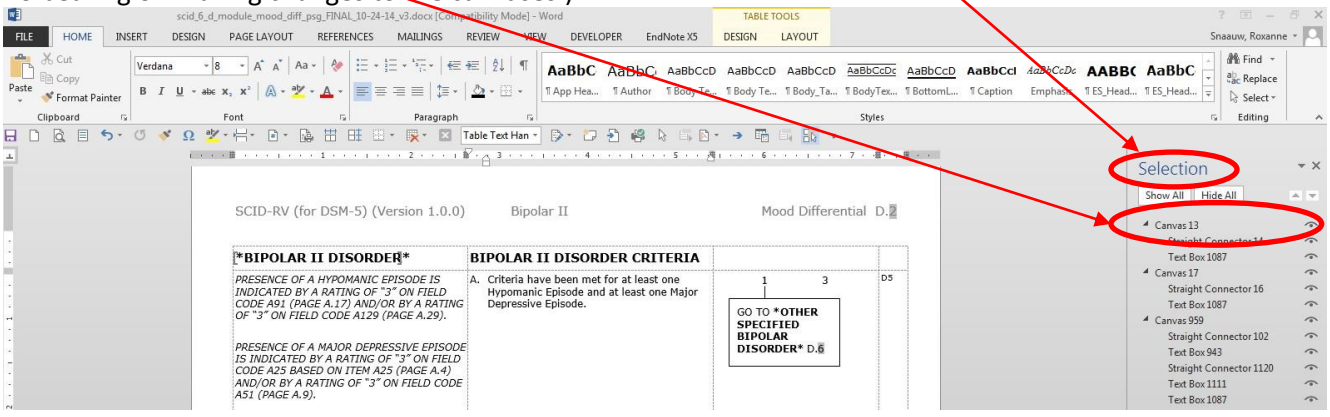
To understand how the drawing canvas functions in MS Word, it is important to understand that the document is made up of two layers. The basic text of the SCID-5-RV is contained in what is called the *document layer*. The graphical elements are contained in a separate *drawing layer* that floats above or below the *document layer*. The graphical objects in the *drawing layer* do not interact with the text in the *document layer* because you cannot actually draw inside the *document layer*. Think of the *document*

layer and the *drawing layer* as two slices of bread: a slice of white bread (*document layer*) and a slice of wheat bread (*drawing layer*) with nothing between them. One of the slices will always be on top and, when working with an MS Word document that has a document layer and a drawing layer (like the SCID-5-RV), you need to designate which layer will be on top, depending on the work you need to do in the file.

Now, let's go through how to work with the drawing canvas. (Note that MS Word 2013 was used to create the screenshots shown below. Some of the screenshots may not look the same if you are working with a different version of MS Word, but the commands used apply as well to MS Word 2007, 2010, and 2013). The easiest way to access the canvas is to have your ***Selection Pane*** open. Go to the Home tab, then click on ***Select*** in the ***Editing*** group (on the very far right), and use the drop-down menu to choose ***Selection Pane***.

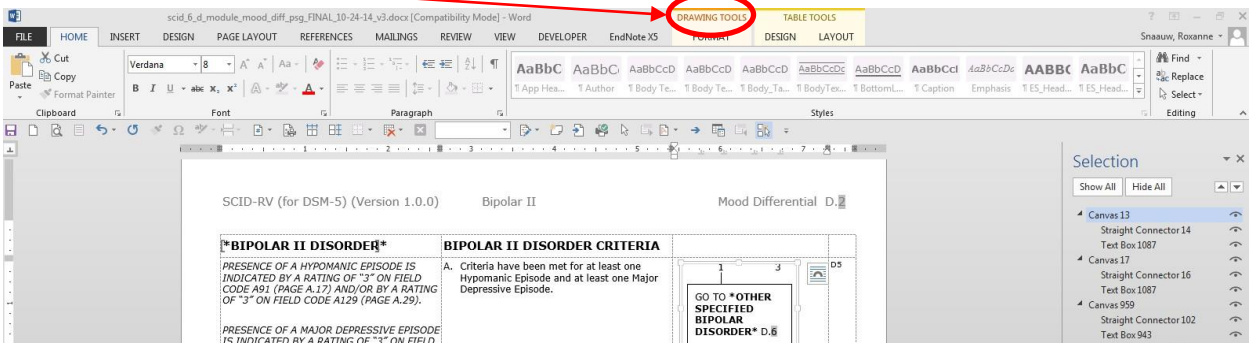


Selecting drawing elements (including text) in the Selection Pane: The purpose of the Selection Pane is to list all the objects on the current page. If you have no drawing canvas in the document, Selection Pane will be grayed out and cannot be selected. From the Selection Pane, you can select a canvas (e.g., ***Canvas 13***) or any of its ***contents*** by clicking the cursor on the canvas label (e.g., Canvas 13) or the content label (e.g., Straight Connector, Text Box). (Note: MS Word assigns numbers to the drawing canvases using rules that are not clear—you can essentially ignore the assigned numbers as they have no bearing on making changes to the canvases.)

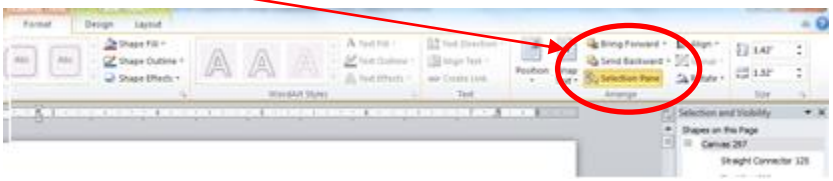


In order to make changes to the graphical elements in the SCID-5-RV, such as changing the "GO TO" instructions inside a text box, you need to bring the drawing canvas in "front" of the text—remember the slices of bread: only one slice can be on top, either the text or the canvas. To make changes to the text of the SCID (contained in the text layer that overlaps with the canvas), you have to place the canvas "behind" the text.

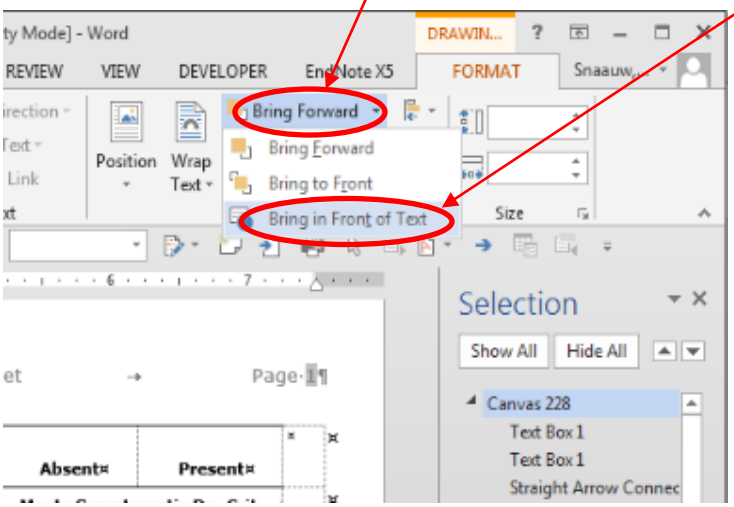
Bringing graphical elements in front of text: If you want the canvas on top of the text so that you can make changes to elements on the canvas, first select the canvas in the Selection Pane. Notice that on the top of the screen there is a new tab that immediately pops up when you do this, called the ***Drawing Tools*** tab (colored orange on most screens).



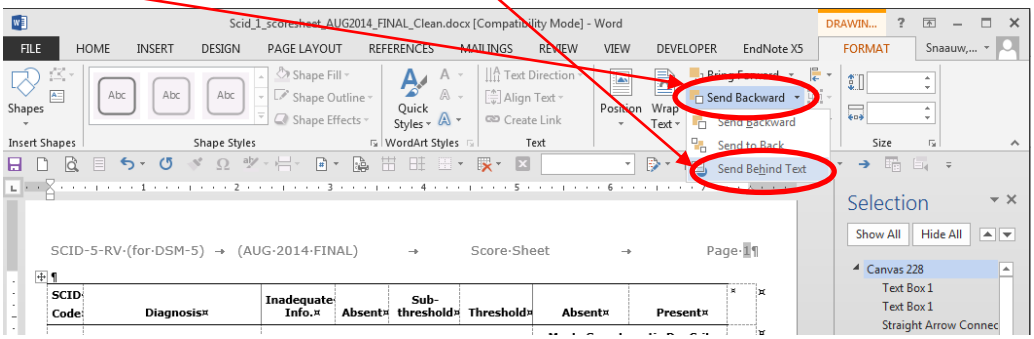
Selecting that tab makes the Drawing Tools menu visible on the top of the screen. Then look for the ***Arrange*** group of icons (on the upper right hand side of the screen).



Within the Arrange group, click on the ***Bring Forward*** drop-down, and select ***Bring in Front of Text.***



If you want the text layer to be the top slice of bread again so that you can make changes to the SCID questions and criteria, you need to send the canvas behind text. Go to the ***Drawing Tools*** tab, ***Arrange*** group, ***Send Backward*** drop-down, and select ***Send Behind Text.***



Updating page references when pages are removed from the SCID-5-RV: The SCID MS Word files employ another advanced feature of MS Word, cross-reference fields, in order to facilitate the renumbering of page references when pages are removed from the SCID-5-RV because they are not needed for a particular study. (Note: As with the drawing canvas feature described above, this cross-reference feature also does not seem to work properly on a Mac computer. A Mac version of the SCID MS Word document files with the page cross-reference feature removed is available.) When pages are removed from the SCID, the page numbering on the upper right hand corner of the page is automatically adjusted. For example, if the assessment of Agoraphobia were to be deleted (i.e., pages F.8–F.13), the first page of the Social Anxiety Disorder assessment automatically becomes page F.8 instead of its original page F.14. However, all the page instructions for "GO TO ***SOCIAL ANXIETY DISORDER*** F.14" throughout the SCID must be changed (from page F.14 to page F.8) to reflect the new page number for Social Anxiety Disorder. There are two ways to fix this. You can either manually replace the incorrect page number (F.14) with its revised page number (F.8), a process that would require you to keep track of all of the page changes, or you can use the cross-reference link feature to have the page number "automatically" change to the new correct page number. This is done by going to every page number reference in a module, selecting the page number using your mouse, unlocking the field by holding down the keys "Ctrl + Shift + F11" (then releasing those keys), updating the field by selecting the F9 key, and then locking the field again by holding down the keys "Ctrl + F11" (then releasing those keys). Unfortunately, there is no way to update all of the page numbers in a single step. Each page number in the SCID module must be individually selected, unlocked, updated, and locked as described above.

2. Modifying the SCID-5-RV to Reflect Inclusion and Exclusion Criteria for a Study

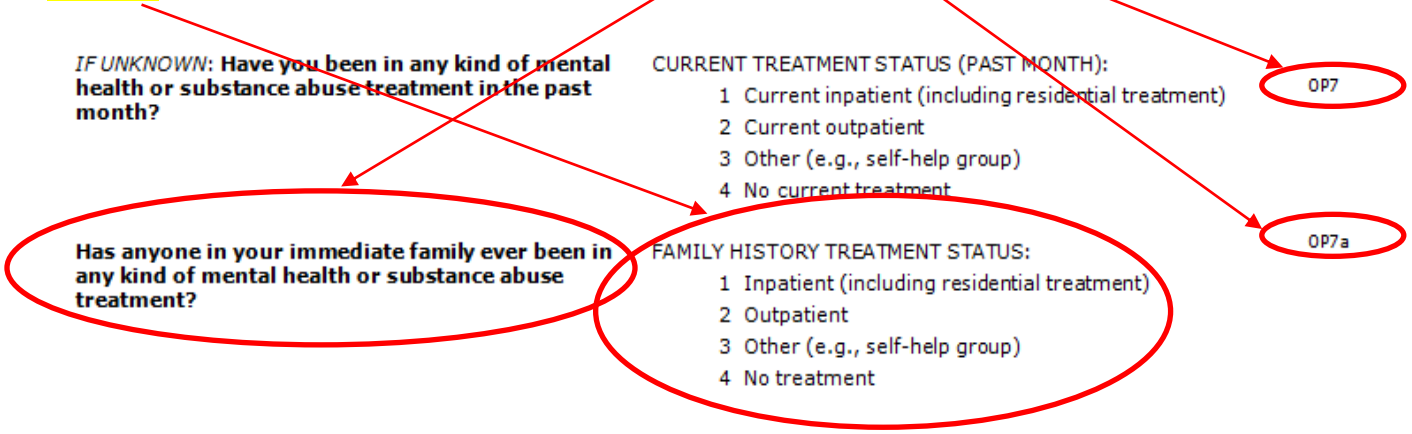
Treatment studies usually have specified inclusion and exclusion criteria, so that if either a diagnosis required in the inclusion criteria is not made or a diagnosis listed in the exclusion criteria is made, the subject is excluded from the study, and there is no point in continuing the SCID interview with that subject. For diagnoses that are required as part of the inclusion criteria for the study, all skip instructions related to a rating of "1" (reflecting the absence of a required criterion) should be replaced with "EXCLUDE FROM STUDY." For example, for studies that require the presence of a current Major Depressive Episode, each of the skip instructions on pages A.1 through A.4 that instruct the interviewer to "GO TO ***PAST MAJOR DEPRESSIVE EPISODE*** A. 5" should be replaced with "EXCLUDE FROM

STUDY." For diagnoses that are part of the exclusion criteria for the study, at each point in the SCID where one of these excluded diagnoses is made, the instruction "EXCLUDE FROM STUDY" should similarly be inserted. For example, in a trial of a new treatment for Major Depressive Disorder, the investigator may want to exclude all subjects with a history of a current or past Manic or Hypomanic Episode. Thus, for each of the SCID items in which the excluded diagnoses are made (i.e., page A.13, field code A70; page A.17, field code A91; page A.22, field code A108; and page A.27, field code A129), the box under the rating of "3" should be replaced with "EXCLUDE FROM STUDY." When the EXCLUDE FROM STUDY instruction is encountered, the interviewer should stop the SCID and gently dismiss the subject, perhaps offering other, nonstudy 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 an Alcohol or Nonalcohol Substance Use Disorder, unless the disorders are present during the past 6 months. The questions about Alcohol or Nonalcohol Substance Use Disorder would need to be modified to inquire only about the presence of symptoms in the past 6 months, rather than the past 12 months—which is the time frame used in the SCID. If a subject's symptoms meet criteria for any Alcohol or Nonalcohol Substance Use Disorder in the past 6 months, the "EXCLUDE FROM STUDY" message should appear on those items where the Alcohol or Nonalcohol Substance Use Disorder diagnoses are made (i.e., for Alcohol Use Disorder, page E.4, field code E13 and for Nonalcohol Substance Use Disorder, page E17, field codes E136, E138, E140, E142, E144, E146, E148, and E150).

3. Adding on to the SCID-5-RV

Investigators may want to collect additional information in the SCID interview. For example, codable family history data may be collected during the Overview with the addition of a few questions and items. The investigator will simply need to insert those questions in the appropriate place in the MS Word version of the SCID and then renumber the ***variable labels*** in the right-hand column to accommodate the additional data. In the example below, a new question was added to the SCID to collect information on a family history of treatment, and a new variable label was also created for the new data (see below).



APPENDIX C: TRAINING MATERIALS

Two types of sample cases are included for training: role-play cases and homework cases.

Role-Play Cases
Five role-play cases are useful for practicing how to administer the SCID-5-RV. These role-play cases work best in groups of two to four, 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 case Overview section aloud to the other members of the group. This is in lieu of doing the entire SCID-5-RV Overview, which we have found to be particularly difficult to role-play. The interviewer should then begin the practice interview with Module A. For the purposes of these role-play exercises, assume that the Screening Module has NOT been used; thus, in Role-Play Case 4, for the initial disorder questions in Modules F and G, the interviewer should pick the third version of the initial screening question (i.e., for cases in which the Screening Module is not used). The person playing the subject should follow the instructions about how to answer the questions so that multiple small groups involved in the role-play case 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 within and between groups.

Homework Cases
Nine homework cases (adapted from the *DSM-IV-TR Casebook* [Spitzer et al. 2002], with some changes to facilitate the application of the diagnostic criteria) are intended to help the interviewer practice how to navigate through Modules C and D of the SCID-5-RV. When administering the SCID-5-RV, the interviewer is expected to go through Modules C and D with the subject sitting in front of him or her, so the interviewer has the opportunity to ask additional clarifying questions. It is therefore advisable for the interviewer to become proficient in using Modules C and D before interviewing an actual subject. Each case should be read and then "coded" as if administering the SCID to that subject, starting at the beginning of Module A. If information for rating a particular criterion is not mentioned in the case vignette, assume it has not been present and assign a rating of "1." The discussion following each case indicates the correct "pathway" through the SCID-5-RV, providing the ratings for pertinent field codes in each case.

ROLE-PLAY CASES

Role-Play Case 1 (for practicing Modules A and B): "Depressed Truck Driver"

(Read this aloud to the interviewer)
OVERVIEW: This is a 50-year-old divorced male who reports having been depressed for the past 6 months. He works as a truck driver but is in danger of losing his job from missing so much work lately. He reports that some days he'll just sit on the edge of his bed, staring at the floor, unable to move. 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 when he was going through a divorce. Between these episodes he has felt well.

(For the role-play)
MOOD SYMPTOMS: For the period of the current month (no 2-week period has been particularly worse than the others), report depressive symptoms as follows:

- Acknowledge persistent depression (Criterion A1)
- Acknowledge loss of interest (Criterion A2)
- Acknowledge loss of appetite accompanied by a 20-pound weight loss (Criterion A3)
- Acknowledge trouble falling asleep (tossing and turning for 2 hours) and then waking up at 5 A.M. (Criterion A4)
- Deny psychomotor agitation (first half of Criterion A5) but acknowledge severe psychomotor retardation (Criterion A5). (Alternatively, you can demonstrate the severe psychomotor retardation if your acting skills are up to it.)
- Acknowledge fatigue or loss of energy (Criterion A6)
- Deny feelings of worthlessness and report feelings of guilt (Criterion A7), but do not give details unless the interviewer asks for them. 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 with him when he was a little boy).
- Deny difficulty concentrating or making decisions (Criterion A8)
- Deny suicidal ideation (Criterion A9).

If the interviewer asks about how the depression has affected your life, remind the interviewer that you have been unable to work because of the depression and that although you have lived alone since your divorce 10 years ago, you have a lot of good friends. However, because of your depression, you have isolated yourself from them. You are in good health and have not started using (nor increased the amount of) alcohol, drugs, or medications. When asked how many separate times in your life that you have been depressed, say two times—now and 10 years ago.

IF VERSION OF MODULE A BEING USED FOR THE ROLE-PLAY INCLUDES MOOD SPECIFIERS:
For the questions about "With Anxious Distress," tell the interviewer that during this current 6-month episode of depression, you have also been feeling very anxious on those days when you are depressed. Specifically, you have:

- Been feeling keyed up and tense (Criterion 1)
- Been unusually restless (Criterion 2)
- Had trouble concentrating because you were worried about what was going to happen to you (Criterion 3)
- Not been feeling afraid that something awful might happen (Criterion 4)
- Felt that your anxiety and worry were going to get out of control (Criterion 5)

If the interviewer asks if you were pacing, moving around a lot, or unable to sit still when you were anxious, deny that this has been happening.

For the questions about With Mixed Features:

- Deny that you felt on top of the world during the 6-month period when your mood was depressed (Criterion A1)
- Deny that you felt more confident than usual (Criterion A2)
- Deny that you were much more talkative than usual (Criterion A3)
- Say that your thoughts about feeling guilty and that you have let your son down have been racing through your head when you are depressed (Criterion A4)
- Deny that you have been especially energetic, productive, or busy (Criterion A5)
- Say that you did do something that has caused trouble for you or your family, namely not going to work (Criterion A6)
- Say that while you have gotten much less sleep than you normally do since you have been depressed, it is not the case that you need less sleep; you are exhausted every day (Criterion A7)

For the questions about With Melancholic Features, clarify that the worst period of depression was about 2 months ago:

- Answer "YES" if the interviewer asks to confirm whether you have lost pleasure in all activities and that nothing gives you pleasure (although the interviewer may not ask this question) (Criterion A1)
- Say that even if something good happened or if your friends tried to cheer you up, you did not feel better at all—nothing could get you out of your down mood (Criterion A2)
- Answer "YES" to the question about whether your mood was different from the kind of feeling you might get if someone died (Criterion B1)

- Answer "YES" that when it was at its worst 2 months ago, you felt regularly worse in the morning (Criterion B2)
- Answer "YES" that you were waking up every morning at 3 A.M. (as opposed to 5 A.M. now) and could not fall back asleep (Criterion B3)
- If asked, report that you had been moving very slowly, even worse than now (Criterion B4)
- If asked, say that you had completely lost your appetite and ate virtually nothing during that time (Criterion B5)
- If asked, say that 2 months ago you were feeling very guilty, as you are now (Criterion B6).

The next question asks whether you have been bothered by depressed mood more days than not for the past 2 years, to which you should answer "NO." The should be followed by a question asking whether you have ever had a period of time lasting 2 years in which you were depressed more days than not and to that you should answer "NO" as well.

The next question to you should be about whether you have been manic in the last month. Answer "NO" to the question about whether there was a period of time in the past month when you were feeling good, high, or excited. Answer "YES" to the question about whether during the current month you had a period when you were irritable, angry, or short-tempered most of the day. Explain that when you get depressed, you get very irritable and short-tempered and any little thing can set you off. Answer "NO," however, to the follow-up question about feeling hyper and having an unusual amount of energy. As you explained earlier, you feel slowed down and have no energy at all. 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. Deny that you have neither had lots of times when you have been feeling high, excited, or irritable, nor lots of times in which you were feeling down or depressed in the past 2 years. Also deny feeling down for more days than not in the past 2 years.

PSYCHOTIC AND ASSOCIATED SYMPTOMS: Answer "NO" to everything except the following:

1) Answer "YES" to the first question about whether people pay special attention to you. Explain that you stay inside because if you go on the street people keep asking why you're not at work.
2) Answer "YES" to the second question under Delusions of Guilt ("Have you ever felt that something you did, or should have done but did not do, caused serious harm to your parents, children, other family members, or friends?"). Reiterate how terribly guilty you feel that you are the cause of your son's drug addiction because you did not play with him enough when he was a little boy because you were away so much.

SCID-5 Diagnosis

Major Depressive Disorder, Recurrent, Severe, Without Psychotic Features, With Anxious Distress, and With Melancholic Features.

Role-Play Case 2 (for practicing Modules A and B): "World Peace Through Meditation"

(Read this aloud to the interviewer)
OVERVIEW: This divorced 30-year-old woman is brought to the hospital by her family, because over the past 3 weeks she has quit her job as a receptionist in a doctor's office, put her house on the market, and has not been sleeping; her behavior has been increasingly bizarre. She is very angry about her hospitalization, believing that her family just wants to prevent her from sharing her good news with the world.

(For the role-play)
MOOD SYMPTOMS: Answer "never" to all questions about depression and loss of interest. In response to the question about feeling good, "high," excited, or "on top of the world," explain that you are feeling "joyous" about quitting your old job and your newly discovered ability to teach meditation, and that you have been feeling this way for over 3 weeks now. In response to the follow-up question about being "hyper" or "wired," explain that you also have a tremendous amount of energy to do things and that you are thrilled about all of the great things that you have been doing and are about to do.

For the Criterion B symptoms:

- When asked about how you feel about yourself, say that you feel great, that you are especially excited about discovering that you have a special power to teach other people how to meditate "through osmosis," and that you are going to bring about world peace by opening a meditation center in California. When the interviewer (hopefully) asks you more details about how this works, explain that you can teach people to meditate simply by staring at them intently for a few minutes and then they can meditate. You know you have been successful because of the look in their eyes after you do it (Criterion B1).
- When asked about your sleeping (Criterion B2), say that you have not slept for 10 days because you are so excited about your new powers.
- When asked about talking too much (Criterion B3), 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 B4), say your mind is "flooded" with ideas about your new meditation center.
- When asked about distractibility (Criterion B5), say YES, but don't give any examples.
- When asked about increase in activities (Criterion B6), say you have been going all over town to TV and radio stations trying to get the news out.
- When asked about doing anything that could get you in trouble (Criterion B7), say that you got arrested when you tried to barge into the NBC Nightly News studios to share your message on air.

You are and always have been in excellent health and you deny having taken 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. Answer "NO" to the questions about having the feeling that the words in a song, what people were wearing, or street signs or billboards were meant to give you a message.

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. Answer "NO" to the question about having the feeling of being followed or spied on and "NO" to the question about being poisoned.

In response to questions about having special powers, respond by saying "How did you find out? Is it all over the news already?" and explain again about your power to teach people to meditate through osmosis, and how once everyone can do this, there will no longer be any need for war and that is why there will be world peace. Answer "NO" to the question about having a close relationship with someone famous.

Answer "NO" to the questions about being convinced that something is wrong with you physically, or that something strange is happening to parts of your body. Answer "NO" to the questions about having committed a crime or that you have done something that caused serious harm to the family.

Answer "NO" to the questions about being convinced that a partner was unfaithful. Answer "YES" to the question that you are a religious or spiritual person, explaining that you were raised Catholic and used to go to church every Sunday, but although you no longer go regularly you still consider yourself religious. Then answer "NO" to the question about having any religious or spiritual experiences that other people have not experienced and "NO" to the question about whether God, the devil, or some other spiritual being has communicated directly with you.

Answer "NO" to the question about a secret admirer or being involved romantically with someone famous. Answer "NO" to the remaining delusional questions about feeling controlled, having thoughts put into your head, having thoughts taken out of your head, feeling that your thoughts are being broadcast out loud, or believing that someone can read your mind.

In response to the question about hearing voices, say that sometimes you hear your name being called. When that happens, you turn in the direction from where you've heard it, but no one is there. Say "NO" to all other hallucinations.

SCID-5 Diagnosis

Bipolar I Disorder, Manic, Severe, With Psychotic Features

Role-Play Case 3 (for practicing Modules A, B, and C): "The Stalker"

(Read this aloud to the interviewer)
OVERVIEW: This is a single 35-year-old female administrative assistant who says she has been "pursued" by a police officer ever since she appeared in court for a speeding ticket 10 months ago.

(For the role-play)
MOOD SYMPTOMS: In response to questions about current depression, say your mood is "distraught" and "upset" and that you've felt that way for weeks, but answer "NO" to feeling sad, depressed, down, or hopeless. Answer "NO" to the question about whether you have lost interest or pleasure in things you enjoyed. If the interviewer decides to continue with the questions for a current depressive episode, answer "NO" to all of the depressive symptom questions except answer "YES" to the question about having trouble falling asleep (Criterion A4) and "YES" to the question about having trouble concentrating (Criterion A8), because you are so frightened about what the police officer means to do to you.

Answer "NO" to having had any other times in the past when you have felt depressed or down and "NO" to the question about ever having lost interest or pleasure in things you usually enjoyed.

Answer "NO" to current and past manic questions (i.e., you never any periods of feeling so good, "high," excited, or "on top of the world" that other people thought you were not your normal self and never any periods of feeling irritable, angry, or short-tempered lasting for at least several days).

Answer "NO" to the initial question for Cyclothymic Disorder ("for the past couple of years, have you had lots of times in which you were feeling high, excited, or irritable, as well as lots of time in which you were feeling down or depressed?"). In response to the initial question for current Persistent Depressive Disorder ("Since (2 YEARS AGO), have you been bothered by depressed mood most of the day, more days than not?"), say that while the court appearance occurred 10 months ago, it's only in the last few weeks that you've realized he is stalking you and have been so upset. If asked, clarify that therefore, you have not been depressed more days than not in the past 2 years. Answer "NO" to the question about ever having had a period lasting 2 years when you were depressed more days than not.

In response to the question about whether you had mood symptoms such as "anger, irritability, anxiety, or depression that developed before your period and then went away during the week after your period," explain that you always feel more emotional right before your period, that this goes away during the week after your period, and this stays away until the week before your next period.

In response to the questions about the most severe premenstrual time in the past year:

- Answer "YES" to mood swings in which you suddenly felt sad or tearful, and "YES" to the question about whether this went away when your menstrual period began (Criterion B1)
- Answer "NO" to being irritable or angry (Criterion B2)
- Answer "NO" to being very sad, down, depressed, or hopeless (Criterion B3)
- Answer "NO" to being extremely anxious or tense during this premenstrual period (Criterion B4).

In response to the next set of questions about other experiences that go along with these mood symptoms:

- Answer "NO" to losing interest in work or school, going out with friends, or in your hobbies (Criterion C1)
- Answer "NO" to having difficulty concentrating (Criterion C2), and "NO" to the question about low energy (Criterion C3)
- Answer "YES" to having increased appetite, saying you get cravings especially for chocolate ice cream); and "YES" to the question about whether it goes away when your period begins (Criterion C4)
- Answer "NO" to sleeping more than usual or having trouble sleeping (Criterion C5)
- Answer "NO" to feeling overwhelmed by everything (Criterion C6)
- Answer "NO" to having any physical symptoms (Criterion C7).

PSYCHOTIC SYMPTOMS: In response to the initial question about whether people were talking about you or taking special notice of you, explain that the police officer is the only one who has taken special notice of you. You know this because you see him hanging around outside your building at night. And you get hang-ups on your telephone that you're sure are from him. Deny the other questions about delusions of reference (i.e., deny that things on the radio, TV, newspaper, songs, what people are wearing, and street signs or billboards have any special meaning for you).

In response to the question about whether someone is going out of their way to give you a hard time or try to hurt you, say you're not sure why the policeman is doing this or what he wants from you, but you think it's something sexual. Answer "YES" to the question that you have the feeling that you are being followed by the policeman but that you don't know why. If asked, you should explain that you are absolutely sure that he is following you and that is it not just your imagination.

Answer "NO" to the question about being especially important or having special powers and "NO" to the question about having a close relationship with someone famous.

Answer "NO" to the questions about being convinced that something is wrong with you physically, or that something strange is happening to parts of your body. Answer "NO" to the questions about committing a crime or that you had done something that caused serious harm to your family.

Answer "NO" to the questions about being convinced that a partner was unfaithful. Answer "NO" to the question that you are a religious or spiritual person, and then "NO" again to the question about feeling that God, the devil, or some other spiritual being or higher power has communicated directly with you.

Answer "NO" to the question about a secret admirer or being involved romantically with someone famous. Answer "NO" to the remaining delusional questions about feeling controlled, having thoughts put into your head, having thoughts taken out of your head, feeling that your thoughts are being broadcast out loud, or believing that someone could read your mind. Answer "NO" to all of the other questions about delusions.

Answer "NO" to all of the questions about hallucinations. If the interviewer inquires further about visual hallucinations (given that you have said that you have "seen" him hanging around building), explain that

you have seen what looks to you like this police officer night after night, driving up and down the street, pretending to patrol the neighborhood—and that although he is not close enough for you to actually see his features, you are sure it is him.

If asked, deny that there was a recent period of time when you were not working, not in school, or unable to take care of things. If asked how you spend your time, say that you have been working as an administrative assistant for the past 10 years full-time and that you really enjoy your work because it is so interesting.

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

SCID-5 Diagnosis

Delusional Disorder, Persecutory Type

Role-Play Case 4 (for practicing Modules F and G): "Driving Me Crazy"

(Read this aloud to the interviewer)
OVERVIEW: This 28-year-old Latina mother of two small children is seeking treatment for a fear of driving that has become progressively more disturbing to her. She has been frightened of driving since she was a teenager, but it has become much worse over the past few years. She is afraid she will pass it on to her children—they recently began showing resistance to riding in the car. In the patient's words, "This is literally driving me and my family crazy!"

(For the role-play)
MOOD SYMPTOMS: Answer "NO" to all the questions about mood symptoms: you've never been depressed for more than a day or two at a time, have never been elated or irritable, have not had periods of elated and depressed mood lasting 2 years, have never been depressed more days than not in the last 2 years, and have not had any mood symptoms premenstrually.

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 SYMPTOMS: Answer "YES" to the initial panic attack question and describe the last bad one you had, which was 2 weeks ago when you thought you were going to have to drive to a store with your children to try on sneakers because your husband was away. (It turned out that his trip was canceled so he ended up driving them). When you describe it, tell the interviewer how your heart was racing, you were sweating, you felt faint, and you were short of breath. Acknowledge that the symptoms came on all of a sudden and got bad within a few minutes.

In response to the questions about specific symptoms associated with the panic attack:

- Answer "YES" to your heart racing (Criterion A1)
- Answer "YES" to sweating (Criterion A2)
- Answer "YES" to trembling (Criterion A3)
- Answer "YES" to shortness of breath (Criterion A4)
- Answer "NO" to feelings of choking (Criterion A5)
- Answer "YES" to chest pain (Criterion A6)
- Answer "NO" to nausea or abdominal distress (Criterion A7)
- Answer "YES" to feeling dizzy (Criterion A8)
- Answer "NO" to flushes or hot flashes (Criterion A9)
- Answer "YES" to tingling (say it was in your hands) (Criterion A10)
- Answer "NO" to derealization (Criterion A11)

- Answer "NO" to fear of losing control (Criterion A12)
- Answer "NO" to fear of dying (Criterion A13)

When the interviewer asks if any of these attacks came on out of the blue, explain that the panic attacks only happen when you are actually driving or anticipating that you will have to drive somewhere. At this point, the interviewer should ask you about other situations in which panic attacks might have occurred, and you should say that they have only occurred in connection with driving.

Answer "YES" to the question about being afraid of going out of the house alone (page F.8) and of driving your own car, but make it clear that the only situation you are afraid of is driving *your* car. You avoid other situations only because they would involve driving.

Answer "NO" to the question about being especially nervous in social situations, but answer "YES" to the question about whether you are afraid to do things in front of other people (page F.14). Explain, however, that this is limited to being nervous about speaking in front of large groups of people and that you think it is not any more than most people would feel. Deny that there are any other social or performance situations that make you nervous (Criterion A).

If the interviewer chooses to continue with the Social Anxiety Disorder assessment:

- To the question "What were you afraid would happen when you had to speak in front of a large group of people?" explain that you would be afraid of being embarrassed by saying something stupid (Criterion B)
- To the question "Have you almost always felt frightened when you have to speak in front of a large group of people?" say that you almost always feel frightened if you have to speak in front of a large group of people (Criterion C)
- In response to the question "Did you go out of your way to avoid speaking in front of people?" answer that in those few instances where you had to speak in front of a group of other people, like in class in high school, you would skip class (Criterion D)
- When asked what would be the likely outcome of a bad performance speaking in front of a large group, say that you would be embarrassed but nothing else would happen (Criterion E)
- When asked about how long it lasted, say that you have felt this way since you were a child (Criterion F)
- When asked what effect this fear of speaking in front of large groups has had on your life, say that it has had very little impact because such situations rarely arise and there are no negative implications for avoiding speaking in front of large groups of people (Criterion G).

In response to the initial question for Specific Phobia ("Are there any other things that have made you especially anxious or afraid, like flying, seeing blood, getting shot, heights, closed places, or certain kinds of animals or insects?"), explain that you are afraid of driving because of a fear of getting lost, having car trouble, or getting into an accident. You're afraid that you won't be able to get help and will be stranded.

In response to the question about almost immediately feeling frightened if you have to drive, answer "YES," explaining that you start to become anxious whenever you anticipate the need to drive. In

response to the question about going out of your way to avoid driving, acknowledge that you do go out of your way to avoid driving, and have sometimes had the kids stay overnight with a relative if your husband is away. Often, anxiety and panic attacks are debilitating, and you cannot bring yourself to get in the car, much less drive it. Sometimes, however, if you have to drive and cannot get your husband to do it, you can force yourself to do it, although with extreme difficulty.

In response to the question "How dangerous would you say it actually is to drive?" say that you recognize that your fear of driving is excessive and you understand that it is not actually that dangerous to drive because you can call your husband or the police if you get into trouble, but you still feel anxious nonetheless.

If asked about how long the fear of driving as lasted, say that you have had these fears since you were a teenager but that they have gotten worse in the past few years. When asked about the impact of these fears on your life, explain that because your husband does the driving for you, the impact of your fear of driving on your life is relatively limited; you do acknowledge that it has put a strain on your marriage because of your reliance on your husband to drive. The bigger problem right now is that you're especially upset about not being able to control the fear because you can see your kids getting anxious about riding in the car, which is why you finally came for treatment.

For the Chronology section (page F.21), confirm that you have had this fear of driving in the past 6 months, that during the past 6 months you have actively avoided driving, and that over the past 6 months you have been very upset about your inability to control this.

If asked by the interviewer, confirm that you did have a panic attack in anticipation of needing to drive during the past month.

Answer "YES" to the question about whether you have felt anxious and worried for a lot of the time over the last several months. Explain that in addition to your fears about driving, you find yourself racked with worry about almost everything. You worry about whether your husband will get killed while on a business trip, about whether your children will develop a deadly illness, about your finances (despite the fact that your husband assures you that he is making a good living and his job is secure), about whether you are being a good enough mother, and so forth. Acknowledge that you worry even when there is no reason and that your husband is constantly saying that you worry too much. Answer "YES" to the question about whether you have been worrying more days than not over the past 6 months.

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 Generalized Anxiety Disorder symptom questions:

- Answer "YES" to feeling on edge (Criterion C1)
- Answer "YES" to feeling tired a lot of the time (Criterion C2)
- Answer "NO" to having trouble concentrating (Criterion C3)
- Answer "NO" to irritability (Criterion C4)

- Answer "NO" to muscle tension (Criterion C5)
- Answer "YES" to having trouble getting to sleep because you think about all the things that might go wrong (Criterion C6)

In response to the question about what effect this has on your life, answer that you have to call your husband every day to make sure he can pick up the kids after 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 and you do not use drink or use drugs, nor do you drink more than one cup of coffee a day.

Answer "NO" to the three screening questions about obsessions (i.e., thoughts that kept coming back, images that kept coming back, and urges that kept coming back). Answer "YES" to the question about whether there was something you have had to do over and over again. Explain that you have to 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 5–10 minutes a day, and you insist that you are NOT bothered by it and that it does NOT significantly interfere with your life.

If the enhanced version of the SCID is being used:

- Answer "NO" to the screening questions for Hoarding Disorder, Body Dysmorphic Disorder, Trichotillomania, and Excoriation Disorder

SCID-5 Diagnoses

Specific Phobia, Situational Type, With Panic Attacks
Generalized Anxiety Disorder

Role-Play Case 5 (for practicing Module E): "Too Busy"

(Read this aloud to the interviewer)
OVERVIEW: This 40-year-old Mexican American male is interviewed in a community study. He has never been married and lives alone. He is a swimming pool contractor currently in the midst of his busy season, working 60 hours a week, and spending evenings at the hospital visiting his terminally ill mother. During the alcohol and substance screening section of the Overview, the subject reports that in the past month, he has been drinking two glasses of wine with dinner and three to four beers during a social evening. With respect to drug use in the past month, the subject reports getting some sleeping pills (zolpidem) from a friend and taking as many as he needs to fall asleep, which is usually two or three. This has been going on since his mother went into the hospital, about 3 weeks ago. He denies any other drug use in the past month.

With regard to lifetime alcohol use, the subject reports having drunk the most during his senior year in high school, when he drank four to five beers plus two to three mixed drinks a day for several months, while he was hanging out with a "bad" group of friends. With respect to other drug use, he reports an extensive history of drug use from the ages of 25 to 35. The 12-month period of most extensive use was around age 30. During that time, he smoked marijuana every day, three or four joints, sometimes beginning right after breakfast. When it was available, sometimes for months at a time (because he was dealing it), he snorted cocaine daily. He used LSD about once per month during that time period. Based on this history, the coding for the drug use table in the Overview is as follows:

For Lifetime (any year other than past year): Sedatives-Hypnotics-Anxiolytics = "1"; Cannabis = "3"; Stimulants (Cocaine) = "3"; Opioids = "1"; Hallucinogens (LSD) = "3"; PCP = "1"; Inhalants = "1"; Other/Unknown = "1."

For past 12 months: Sedatives-Hypnotics-Anxiolytics = "3"; all others are rated "1."

(For the role-play)
MOOD SYMPTOMS: Answer "YES" to the current depressed mood question, but when the interviewer asks about whether the depressed mood is present "most of the day, nearly every day," answer "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 again that you don't have time to do anything but work, visit your mother, and sleep—but you are still interested in work and visiting your mother. 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: For the initial question about alcohol ("drunk alcohol at least six times in the past 12 months"), reiterate that you have been drinking two glasses of wine with dinner and three to four beers when you go out with friends in the evening, which is about twice a week.

With regard to the questions evaluating Alcohol Use Disorder in the past 12 months, say "NO" to all 11 of the Alcohol Use Disorder questions: the drinking has not caused any problems in the past 12 months nor is it out of control. The interviewer should then ask whether, besides the past 12 months, you have

ever drunk alcohol at least six times in a 12-month period, and you should say "YES," in your senior year in high school. When asked to pick the 12-month period when you were drinking the most, pick your senior year in high school.

For that period respond as follows:

- Answer "NO" to taking larger amounts or over a longer period than intended (because you did not care how much you were drinking) (Criterion A1)
- Answer "NO" to having a persistent desire or unsuccessful efforts to cut down (you did not want to cut down nor did you try during the time period) (Criterion A2)
- Answer "YES" to spending a lot of time drinking or hung over (most of the day, nearly every day that year) (Criterion A3)
- Answer "NO" to craving (Criterion A4)
- Answer "YES" to missing school because you were drunk or hungover (in fact, you failed several courses during your senior year because of your drinking and had to go to summer school to make up those courses) (Criterion A5)
- Answer "YES" to problems with friends (you would get into fights with your friends when you got drunk) (Criterion A6)
- Answer "NO" to reducing time spent at work or school, with family or friends, or on things you like to do (Criterion A7)
- Answer "YES" to having had a few drinks right before driving. When the interviewer (hopefully) asks you how much you had to drink, say that actually there were several occasions on which you had six or seven vodkas right before driving but deny that this affected your coordination or concentration or your ability to drive (Criterion A8)
- Answer "NO" to alcohol causing problems like making you depressed or causing blackouts and to alcohol causing a significant physical problem (Criterion A9)
- Answer "YES" to tolerance, saying that when you first started drinking around age 14 you got a "buzz" after only one or two drinks, but by this time, it would take four drinks to get the same feeling (Criterion A10)
- Answer "NO" to withdrawal symptoms or starting the day with a drink (Criterion A11).

For the Nonalcohol Substance Use Disorders, the interviewer should start with the assessment for Past-12-Month Substance Use Disorders for the zolpidem prescription abuse, given that you have taken a medication that is not prescribed for you and are taking more than the normal dose, which is one tablet. The interviewer should thus concentrate only on the sedative-hypnotic-anxiolytic class. (It does not matter which of the three assessment options are used because there is only one drug class being evaluated.) The following answers should be given:

- Answer "NO" to using more than intended (say that you take as many as you need to help you sleep—you don't care how many it takes to do that, so you don't set a limit of only one or two) (Criterion A1)
- Answer "NO" to any desire to cut down or having unsuccessful efforts (Criterion A2)

- Answer "NO" to spending a lot of time getting or taking the drug (it is easily accessible from your friend; it only takes a few seconds to take each pill, and the effects only last during the time needed for sleep; there is no hangover) (Criterion A3)
- Answer "NO" to any craving for the sleeping pills when you are not taking them (Criterion A4)
- Answer "NO" to the sleeping pills causing you to miss work, getting you into trouble, etc. (Criterion A5)
- Answer "NO" to the sleeping pills causing you problems with people (Criterion A6)
- Answer "NO" to giving up any activities because of your use of sleeping pills (Criterion A7)
- Answer "NO" to having taken any sleeping pills before driving or doing anything else that requires concentration, as you take them only before trying to go to sleep (Criterion A8)
- Answer "NO" to causing you any psychological or physical problems (Criterion A9)
- For the question about tolerance, say that when you started taking the sleeping pills, it seemed that only one pill was enough, but after a couple of weeks, one pill no longer did the trick and you found that you needed at least two, and sometimes three pills, to get to sleep (Criterion A10)
- You have taken the zolpidem every night since you started and have not tried to stop yet. However, you don't seem to have any withdrawal symptoms during the day, and you are not taking it to keep yourself from getting sick (Criterion A11).

For the assessment of Prior-to-12-Month Substance Use Disorder, based on the information from the Overview, the interviewer should circle the Sedative column, the Cannabis column, the Stimulants column, and the Hallucinogens column.

Any of the three assessment options can be used for the role-play. The most problematic drug for the purposes of Option #1 is the Stimulants. For Option #2, the three most-used drug classes are Cannabis, Stimulants, and Hallucinogens, and all three are checked in parallel. For Option #3, all three drug classes are also checked in parallel. Below are the instructions for how to answer questions for each of the three drug classes. Tailor your answers as follows, according to how the interviewer asks the questions.

Criterion A1 (taking more than intended):
Cannabis: Answer "NO"—you were smoking pot throughout the day, felt that it was not causing any problem, and thus never had any "intended" amount that was exceeded.
Cocaine: Answer "YES"—your cocaine use was out of control; you often used up all your cocaine in one evening, even when you had an amount that should last for a week.
Hallucinogens: Answer "NO"—you would decide to do one "hit" in the evening and that was it.

Criterion A2 (persistent desire or unsuccessful efforts to cut down)
Cannabis: Answer "NO"—you had no desire to stop or cut down and made no attempts to do so.
Cocaine: Answer "YES"—you tried to stop many times, but succeeded only when you moved to a place where it was not easy to get.
Hallucinogens: Answer "NO"—you had no desire to stop or cut down and made no attempts to do so.

Criterion A3 (great deal of time spent)
Cannabis: Answer "YES"—you were high all day.
Cocaine: Answer "YES"—age 30 was one of the times when you were using it every day—"coked up" all the time.
Hallucinogens: Answer "NO"—you used it only once a month.

Criterion A4 (craving)
Cannabis: Answer "YES"—you were craving it as soon as you woke up and starting smoking right after breakfast.
Cocaine: Answer "YES"—you always craved it when you were not using it.
Hallucinogens: Answer "NO"—you enjoyed it once a month but did not think about it at other times.

Criterion A5 (use resulting in failure to fulfill major role obligations)
Answer "NO" to all three drug classes—during this time, you were fully occupied as a drug dealer; being high had no negative impact on this; and you were not working, going to school, or in the role of taking care of family.

Criterion A6 (continued use despite having social problems)
Cannabis: Answer "YES"—your family disapproved, and there were constant arguments about your being high on marijuana every day.
Cocaine: Answer "YES"—your family disapproved of both drug use and drug dealing, with constant arguments.
Hallucinogens: Answer "NO"—your family was not aware of your hallucinogen use.

Criterion A7 (activities given up)
Cannabis: Answer "YES"—you stopped spending time with family and friends; you no longer played sports.
Cocaine: Answer "YES"—you stopped spending time with family and friends; you no longer played sports.
Hallucinogens: Answer "NO"—your use was not frequent enough.

Criterion A8 (use when physically hazardous)
Cannabis: Answer "YES"—you smoked pot before driving and answer "YES" to follow-up question about impaired coordination.
Cocaine: Answer "YES"—you snorted cocaine before driving, but answer "NO" to reckless or risky driving.
Hallucinogens: Answer "YES"—you took LSD and went driving at least three times during that time period; taking LSD made it more difficult to drive; luckily you did not get into any car accident.

Criterion A9 (use despite knowledge of psychological or physical problem)
Cannabis: Answer "NO" to psychological problems; answer "YES" to physical problem (you have asthma and marijuana use would sometimes trigger an asthma attack); and answer "YES" to whether you kept using it anyway.
Cocaine: Answer "YES" to psychological problems (cocaine would make you very paranoid; you would lock the doors of your house and become convinced that other drug dealers or the police were watching you); answer "YES" to whether you kept using it anyway; answer "NO" to physical problems.
Hallucinogens: Answer "NO"

Criterion A10 (tolerance)
Cannabis: Answer "NO"—it seemed like the same amount would get you high.
Cocaine: Answer "YES"—you needed to escalate the amount used after only a few days.
Hallucinogen: Answer "NO."

Criterion A11 (withdrawal)
Cannabis: Answer "NO."
Cocaine: Answer "YES"—after you would run out of cocaine, you would "crash" and become depressed and irritable, sleep all the time, feel fatigued, and be slowed down.
Hallucinogens: Answer "NO" (if asked).

SCID-5 Diagnoses

Alcohol Use Disorder, Moderate (Criteria A3, A5, A6, A10), In Full Remission
Cocaine Use Disorder, Severe (Criteria A1, A2, A3, A4, A6, A7, A8, A9, A10, A11), In Sustained Remission
Cannabis Use Disorder, Moderate (Criterion A3, A4, A6, A7), In Sustained Remission

HOMEWORK CASES

Homework Case 1: "Low Life Level"

Ms. Larkin, age 39 years, is a pale, stooped, single white woman. Her 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 Ms. Larkin was a supervisor in the occupational therapy department of a large hospital, lived 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 3 months, and from which she was discharged to her mother's house with a prescription for unknown medication that she never 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, and she ate 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	**Field Code, Rating, and Notes**
Page A.1:	A1 = 1; A2 = 1
Page A.5:	A27 = 1; A28 = 1
Page A.10:	A54 = 1
Page A.18:	A92 = 1
Page A.28:	A131 not checked; A132 = 1
Page A.30:	A139 not checked; A140 = 1
Page A.33:	A157 = 1
Page A.36:	A172 not checked; A173 = 1

Module B

Page B.1:	B1–B2 = 1
Page B.2:	B3–B7 = 1
Page B.3:	B8–B13 = 1
Page B.4:	B14 = 1; B15 = 0 (absent); B16 = 1
Page B.5:	B17–B21 = 1; B22 = 0 (absent)
Page B.6:	B23 not checked
	B24 = 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")
	B25 = 3 (present and moderate)
	B26 = 3 (*grossly disorganized behavior*—"she became increasingly disorganized, wandering aimlessly in the street, wearing mismatched clothing")
Page B.7:	B27–B35 = 1
Page B.8:	B36–B38 = 1; B39 = 3 (present and moderate)
	B40 = 3/B41 = 3: (*avolition*—"sitting and staring into space".... "stopped bathing and brushing her hair or teeth")
Page B.9:	B42 = 3/B43 = 3 (*diminished emotional expressiveness*—"her affect was shallow")
	B44 = 3 (present and moderate)

Module C

Page C.1:	C1 not checked; C2 = 3 (psychotic symptoms outside of mood episodes)
	C3 = 3 (disorganized speech, disorganized behavior, and negative symptoms occurring together for at least 1 month)
Page C.2:	C4 = 3 (no mood episode ever)
Page C.3:	C6 = 3 (continuous signs of illness for years)
	C7 = 3 (severe functional impairment)
Page C.4:	C8 = 3 (not due to a GMC or substance/medication)
Page C.5:	C9 = 3 (no history of Autism Spectrum Disorder or a Communication Disorder)
	C10 = 3 (Criteria A, B, C, D, E, and F coded "3")
	C11 not checked
Page C.17:	C52 = 3
	C56 = 27 (age at onset)
	C57 = 1 (one episode)
Page C.18:	C58 = 27 (onset of prodromal symptoms)
	C59 = 7 (continuous)

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 7 months. During the last 4 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 states that about 6 weeks ago, he started hearing "voices." There are several voices, which comment on his behavior and discuss him in the third person. They usually are either benign (e.g., "Look at him now. He is about to eat") or insulting in content (e.g., "What a fool he is—he doesn't understand anything!"). During this time he watches little TV, because he hears the voices coming out of the TV and is upset that the TV shows often refer to him.

For the past 6 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. Starting about 4 weeks ago, he began 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 2 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. He is troubled by the voices that he hears throughout the day, sometimes referring to them as "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 **Field Code, Rating, and Notes**

Page A.1: A1 = 1; A2 = 1

Page A.5: A27 = 1; A28 = 1

Page A.10: A54 = 3 ("Mr. Nehru is euphoric" and has "surges of increased energy")
A55 and A56 both checked (euphoric and irritable)
A57 = 3 (hospitalization was necessary)
A58 = 3 ("he is the new Messiah")
A59 = 3 ("needs very little sleep")

Page A.11: A60 = 3 ("talks with great rapidity and enthusiasm")
A61 = 3 ("speech is rapid and hard to follow")
A62 = 3 ("In the middle of a speech on his new religion, he abruptly compliments the doctor on how well his shirt and tie match")
A63 = 3 ("He paces up and down the ward")
A64 and A65 both checked
A66 = 3 ("standing in the street harassing people about his religious beliefs")

Page A.12: A67 = 3 (at least three B symptoms coded "3")
A68 = 3 (hospitalized and psychotic)

Page A.13: A69 = 3 (not due to a GMC or substance/medication)
A70 = 3 (current Manic Episode)

Page A.14: A71 checked

Page A.36: A172 checked

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")

Page B.2: B3 = 3 ("he is the new Messiah")
B4–B6 = 1
B7 = 3 ("he is the new Messiah")

Page B.3: B8–B13 = 1

Page B.4: B14 = 1
B15 = 4 (present and severe)
B16 = 3 ("troubled by the voices that he hears throughout the day")

Page B.5: B17–B21 = 1; B22 = 4 (present and severe)

Page B.6: B23 not checked; B24 = 1; B25 = 0 (not present); B26 = 1

Page B.7: B27–B35 = 1

Page B.8: B36–B38 = 1; B39 = 0 (not present); B40 = 1

Page B.9: B42 = 1; B44 = 0 (not present)

Module C

Page C.1: C1 not checked; C2 = 3 (psychotic symptoms when not manic for 2 weeks); C3 = 3 (delusions and hallucinations)

Page C.2: C4 = 1 (there ARE Manic Episodes concurrent with active phase symptoms of Schizophrenia)
C5 = 1 (manic symptoms have been present for more than 50% [4 weeks] of the total duration of the illness [6 weeks])

Page C.8: 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 majority of the time)
Page C. 9: C25 = 3 (Not due to a GMC or substance/medication)
C26 = 3 (Criterion A, B, C, and D coded "3")
C27 = 1 (Bipolar Type)
C28 not checked
Page C.17: C54 = 3 (symptoms present at some point during past month)
C56 = 32 (age at onset)
C57 = 1 (one episode)

SCID DX: SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE

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 4 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 2 weeks later, Mr. Polsen noticed that his coworkers 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 2 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 the latest 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 Iraq. 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	**Field Code, Rating, and Notes**
Page A.1:	A1 = 1; A2 = 1
Page A.5:	A27 = 1; A28 = 1
Page A.10:	A54 = 1
Page A.18:	A92 = 1
Page A.28:	A131 not checked; A132 = 1
Page A.30:	A139 not checked ; A140 = 1
Page A.33:	A157 = 1
Page A.36:	A172 checked

Module B

Page B.1:	B1 = 3 ("hit men" in white cars; coworkers turning away)
	B2 = 3 (boss put out a contract on his life)
Page B.2:	B3–B7 = 1
Page B.3:	B8–B13 = 1
Page B.4:	B14 = 1
	B15 = 4 (present and severe)
	B16 = 1
Page B.5:	B17–B21 = 1; B22 = 0 (not present)
Page B.6:	B23 not checked; B24 = 1; B25 = 0 (not present); B26 = 1
Page B.7:	B27–B35 = 1
Page B.8:	B36–B38 = 1; B39 = 0 (not present); B40 = 1
Page B.9:	B42 = 1; B44 = 0 (not present)

Module C

Page C.1:	C1 not checked; C2 = 3 (no mood episode ever)
	C3 = 1 (no hallucinations, disorganized speech or behavior, or negative symptoms)
Page C.10:	C29 not checked; C30 not checked; C31 = 3 (no mood episode ever)
	C32 = 3 (delusion for at least 1 month)
	C33 = 3 (never met criteria for Schizophrenia)
	C34 = 3 (not markedly impaired apart from impact of delusional functioning; no odd or bizarre behavior)
Page C.11:	C35 = 3 (not due to a GMC or substance/medication)
	C36 = 3 (not better explained by another mental disorder)
	C37 = 3 (Criteria A, B, C, D, and E coded "3")
Page C.12:	C38 = 1 (Persecutory Type)
	C39 not checked
Page C.17:	C53 (delusions present in past month)
	C56 = 42 (age at onset)
	C57 = 01 (only one episode)

SCID DX: DELUSIONAL DISORDER, PERSECUTORY TYPE

Homework Case 4: "The Socialite"

Ms. Cabot, a 42-year-old married white 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 Ms. Cabot, 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. Ms. Cabot 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 had to leave to visit a sick relative.

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

Immediately following the funeral, Ms. Cabot became increasingly tense and jittery, and could sleep only 2–3 hours a night. Two days later she happened to see a woman driving a car just like the one her friend had driven. She was puzzled, and after a few hours she became convinced that her friend was alive and 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. She is admitted to the psychiatric unit where she is treated with risperidone, an antipsychotic medication, and within days her symptoms resolve and she returns to her normal self.

SCID Coding for "The Socialite"

Module A	**Field Code, Rating, and Notes**
Page A.1:	A1 = 1; A2 = 1
Page A.5:	A27 = 1; A28 = 1
Page A.10:	A54 = 1
Page A.18:	A92 = 1
Page A.24:	A131 not checked ; A132 = 1
Page A.30:	A139 not checked ; A140 = 1
Page A.33:	A157 = 1
Page A.36:	A172 not checked; A173 = 1

Module B

Page B.1:	B1 = 3 (sees woman driving a car like the one her friend had driven—convinced this means her friend is alive)
	B2 = 3 (plot to deceive her; phone is tapped; room is bugged; she is in danger)
Page B.2:	B3–B7 = 1
Page B.3:	B8–B13 = 1
Page B.4:	B14 = 1
	B15 = 4 (present and severe)
	B16 = 3 (high-pitched "ultrasound")
Page B.5:	B17–B21 = 1; B22 = 3 (present and moderate)
Page B.6:	B23 not checked; B24 = 1; B25 = 0 (not present); B26 = 1
Page B.7:	B27–B35 = 1
Page B.8:	B36–B38 = 1; B39 = 0 (not present); B40 = 1
Page B.9:	B42 = 1; B44 = 0 (not present)

Module C

Page C.1:	C1 not checked; C2 = 3 (no mood episodes ever)
	C3 = 1 (both delusions and hallucinations but lasted less than 1 month)
Page C.10:	C29 not checked; C30 not checked
	C31 = 3 (no mood episodes)
	C32 = 1 (for less than 1 month)
Page C.13:	C40 = 3 (delusions and hallucinations)
	C41 = 3 (duration is at least 1 day but less than 1 month)
	C42 = 3 (not better explained by other mental disorders)
	C43 = 3 (not due to a GMC or substance/medication)
Page C.14:	C44 = 3 (Criteria A, B, and C are coded "3")
	C45 = 1 (With Marked Stressors)
	C46 not checked
	C47 not checked
Page C.19:	C61 = 3 (delusions and hallucinations present in the past month)
	C65 = 42 (age at onset)

SCID DX: BRIEF PSYCHOTIC DISORDER, WITH MARKED STRESSORS

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 7 months. However, he was getting an increasing number of distracting "signals" from coworkers, 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 8 months. However, in the last 5 years he has been hospitalized only once, for 3 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. Mr. Simpson states that everyone on the street watches him. He says that his neighbors operate two different "machines." One machine generates all of his voices (except the voice of the "joker"; he is uncertain who controls this voice, which "visits" him only occasionally and is very funny). He hears the voices from the machine many times each day, and he sometimes thinks the machine is directly run by the elderly neighbor whom he attacked. When he is going over his investments, the "harassing" voices from this machine 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	**Field Code, Rating, and Notes**
Page A.1:	A1 = 1; A2 = 1
Page A.5:	A27 = 1; A28 = 1
Page A.10:	A54 = 1
Page A.18:	A92 = 1
Page A.28:	A131 not checked; A132 = 1
Page A.30:	A139 not checked; A140 = 1
Page A.33:	A157 = 1
Page A.36:	A172 checked

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)
Page B.2:	B3 = 3 ("millions of dollars" being spent, perhaps part of a large experiment to discover the secret of his "superior intelligence")
	B4–B7 = 1
Page B.3:	B8–B9 = 1
	B10 = 3 (machine puts erotic dreams of "black women" in his head)
	B11–B12 = 1
	B13 = 3 (girlfriend replaced by look-alike)
Page B.4:	B14 = 3 (bizarre content)
	B15 = 4 (present and severe)
	B16 = 3 (machine-generated harassing voices every day)
Page B.5:	B17–B21 = 1; B22 = 0 (not present)
Page B.6:	B23 not checked; B24 = 1; B25 = 0 (not present); B26 = 1
Page B.7:	B27–B35 = 1
Page B.8:	B36–B38 = 1; B39 = 0 (not present); B40 = 1
Page B.9:	B42 = 1; B44 = 0 (not present)

Module C

Page C.1:	C1 not checked; C2 = 3 (no mood episode ever)
	C3 = 3 (delusions and hallucinations)
Page C.2:	C4 = 3 (no mood episode ever)
Page C.3:	C6 = 3 (continuous signs of illness for years)
	C7 = 3 (marked functional impairment)
Page C.4:	C8 = 3 (not due to a GMC or substance/medication)
Page C.5:	C9 = 3 (no history of Autism Spectrum Disorder or a Communication Disorder)
	C10 = 3 (Criteria A, B, C, D, E, and F coded "3")
	C11 not checked
Page C.17:	C52 = 3 (symptoms present last month)
	C56 = 22 (age at onset)
	C57 = 99 (too numerous or indistinct to count)
Page C.18:	C58 = 99 (unknown age at onset of prodromal symptoms); C59 = 7 (continuous)

SCID DX: SCHIZOPHRENIA

Homework Case 6: "Agitated Businessman"

Mr. Murray, an agitated 42-year-old married white businessman, was admitted to the psychiatric service after a 2½-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, Mr. Murray had been diagnosed with Narcolepsy because of daily irresistible sleep attacks and episodes of sudden loss of muscle tone when he got emotionally excited. He had been placed on an amphetamine-like 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 4 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	**Field Code, Rating, and Notes**
Page A.1:	A1 = 1; A2 = 1
Page A.5:	A27 = 1; A28 = 1
Page A.10:	A54 = 1
Page A.18:	A92 = 1
Page A.28:	A131 not checked; A132 = 1
Page A.30:	A139 not checked; A140 = 1
Page A.33:	A157 = 1
Page A.36:	A172 checked

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 = 3 (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)

Page B.2: B3–B7 = 1

Page B.3: B8–B13 = 1

Page B.4: B14 = 1
B15 = 4 (present and severe)
B16 = 1

Page B.5: B17–B21 = 1; B22 = 0 (not present)

Page B.6: B23 not checked; B24 = 1; B25 = 0 (not present); B26 = 1

Page B.7: B27–B35 = 1

Page B.8: B36–B38 = 1; B39 = 0 (not present); B40 = 1

Page B.9: B42 = 1; B44 = 0 (not present)

Module C

Page C.1: C1 can be rated in either of two ways. If you are confident that the delusions are due to the excessive stimulant use (which is reasonable given the case description), you could check this item and skip to page C.21. If you are not sure and would prefer to go through the full differential diagnosis, leave this unchecked and continue on page C.1
C2 = 3 (psychotic symptoms but no mood episodes)
C3 = 1 (only delusion of reference)

Page C.10: C29 not checked; C30 not checked; C31 = 3 (no mood episodes)
C32 = 3 (delusion for 2 months)
C33 = 3 (has not met Criterion A for Schizophrenia)
C34 = 3 (behavior not markedly impaired or bizarre)

Page C.11: The assessment of C35 requires that you first jump to page C.21 to assess the etiology of the psychotic symptoms if there is a reasonable likelihood that the psychotic symptoms may be due to a GMC or substance/medication. In this case, both a GMC (e.g., Narcolepsy) and substance use (e.g., methylphenidate) are present, so both Psychotic Disorder Due to Another Medical Condition and Substance/Medication-Induced Psychotic Disorder should be considered.

Page C.21: C67 not checked (psychotic symptoms are temporally related to the Narcolepsy; i.e., they have their onset after the onset of Narcolepsy)
C68 = 3 (delusion of reference)
C69 = 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.23: C73 not checked (symptoms are temporally associated with substance use)
C74 = 3 (delusion of reference)
C75 = 3 (symptoms developed after increasing use of methylphenidate)
C76 = 3 (not better accounted for by primary psychotic disorder, such as Delusional Disorder, because 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/medication-induced psychotic disorder)

Page C.24: C77 = 3 (clinically significant impairment)
C78 = 3 (Criteria A, B, C, and E are coded "3")
C79 = 1 (With Onset During Intoxication)
At this point you are instructed to either "Return to disorder being evaluated" if you skipped to page C.21 from Criterion E within Delusional Disorder (the box in the upper right-hand corner of page C.24 instructs you to turn to page C.11 and resume with your rating of C35), or go to Module D if you skipped to page C.21 directly from the beginning of page C.1.

Page C.11: C35 = 1 (due to direct physiological effects of a substance)

Page C.19: C62 = 3 (symptoms in past month)
C65 = 42 (age at onset)

SCID DX: SUBSTANCE/MEDICATION-INDUCED PSYCHOTIC DISORDER

Homework Case 7: "Bad Voices"

Ms. 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 7 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 2 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 7 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 she refused to discuss her marital problems. About 2 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 disorders clinic. She was evaluated and given haloperidol, 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 disorders clinic because the haloperidol was making her stiff and nauseated and was not helping her symptoms. She denies wanting to kill herself, and cites how hard she is 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 haloperidol on her own 2 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 interviewed the next 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 her 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, Ms. Galvez 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	**Field Code, Rating, and Notes**
Page A.1:	A1 = 1; A2 = 1 (denied depressed mood and diminished interest or pleasure)
Page A.5:	A27 = 1; A28 = 1 (no information on past depressed mood or past diminished interest)
Page A.10:	A54 = 1
Page A.18:	A92 = 1
Page A.28:	A131 not checked; A132 = 1
Page A.30:	A139 not checked; A140 = 1
Page A.33:	A157 = 1
Page A.36:	A172 not checked; A173 = 1

Module B

Page B.1:	B1–B2 = 1
Page B.2:	B3–B7 = 1
Page B.3:	B8–B13 = 1
Page B.4:	B14 = 1
	B15 = 0 (not present)
	B16 = 3 (voices telling her to kill herself)
Page B.5:	B17–B21 = 1; B22 = 2 (present but mild)
Page B.6:	B23 not checked; B24 = 1; B25 = 0 (not present); B26 = 1
Page B.7:	B27–B35 = 1
Page B.8:	B36–B38 = 1; B39 = 0 (not present); B40 = 1
Page B.9:	B42 = 1; B44 = 0 (not present)

Module C

Page C.1:	C1 not checked; C2 = 3 (no documentation of mood episodes)
	C3 = 1 (hallucinations without the other symptoms of Schizophrenia)
Page C.10:	C29 checked (never any delusions)
Page C.13:	C40 = 3 (hallucinations)
	C41 = 1 (duration of hallucinations greater than 1 month)
Page C.15:	C48 = 3 (psychotic symptoms not meeting full criteria for Psychotic Disorder)
	C49 = 3 (causes impairment)
Page C.16:	C50 = 3 (not due to a GMC or substance/medication)
	C51 = 1 (persistent auditory hallucinations)
Page C.19:	C63 = 3
	C65 = 18 (age at onset)

SCID DX: OTHER SPECIFIED PSYCHOTIC DISORDER

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 Ms. Fielding's sister after she had failed to persuade Ms. Fielding to visit an outpatient psychiatrist. The sister was concerned about Ms. Fielding's increasingly erratic work pattern and, more recently, bizarre behavior since the death of their father 2 years ago. Ms. Fielding's only prior psychiatric contact had been brief psychotherapy in college.

Ms. Fielding has not worked since being laid off from her job 3 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 Ms. Fielding 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.

Ms. Fielding 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. She was troubled mostly 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	**Field Code, Rating, and Notes**
Page A.1:	A1 = 1; A2 = 1
Page A.5:	A27 = 1; A28 = 1
Page A.10:	A54 = 1
Page A.18:	A92 = 1
Page A.28:	A131 not checked; A132 = 1
Page A.30:	A139 not checked; A140 = 1
Page A.33:	A157 = 1
Page A.36:	A172 not checked; A173 = 1

Module B

Page B.1:	B1 = 3 (observed people on the street speaking her thoughts aloud)
	B2 = 3 (neighbors are "harassing" her)
Page B.2:	B3 = 1 (her "telepathic powers" are not grandiose in content)
	B4–B7 = 1
Page B.3:	B8–B11 = 1
	B12 = 3 (neighbors "accessing" her thoughts; hearing people on the street repeating what she has thought)
	B13 = 1
Page B.4:	B14 = 3 (bizarre quality)
	B15 = 3 (present and moderate)
	B16 = 3 (heard voices of people on the street below reciting entire menu; voices of upstairs neighbors bombarding her with their own devaluing and critical comments, such as "You're no good" and "You have to leave")
Page B.5:	B17–B21 = 1; B22 = 3 (present and moderate)
Page B.6:	B23 not checked; B24 = 1; B25 = 0 (not present); B26 = 1
Page B.7:	B27–B35 = 1
Page B.8:	B36–B38 = 1; B39 = 0 (not present); B40 = 1
Page B.9:	B42 = 1; B44 = 0 (not present)

Module C

Page C.1:	C1 not checked; C2 = 3 (no mood episodes)
	C3 = 3 (delusions and hallucinations)
Page C.2:	C4 = 3 (no mood episodes)
Page C.3:	C6 = 1 (psychotic symptoms for only 3 months)
Page C.6:	C12 = 3 (psychotic symptoms for 3 months)
	C13 = 3 (not due to a GMC or substance/medication)
Page C.7:	C14 = 3 (Criteria B and D coded "3)
	C15 = 1 (provisional dx—expected recovery has not yet occurred)
	C16 = 3 (acute onset)
	C17 = 1 (no confusion or perplexity)
	C18 = 3 (good premorbid functioning)
	C19 = 3 (no blunted or flat affect)
	C20 = 1 (With Good Prognostic Features)
	C21 not checked

Page C.19: C60 = 3 (meets criteria past month)
C65 = 35 (age at onset)
Page C.20: C66 = 99 (unknown if and when prodromal symptoms started)

SCID DX: SCHIZOPHRENIFORM DISORDER, WITH GOOD PROGNOSTIC FEATURES

Homework Case 9: "Radar Messages"

Ms. Davis, a 24-year-old, single, white copyeditor 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, 3 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 10 pounds; had trouble falling asleep and waking up too early; had severe fatigue, felt worthless, and had great difficulty concentrating on her schoolwork.

After about 2 months of these problems, they seemed to go away, but she then began to feel increasingly energetic, requiring only 2–3 hours of 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, which 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 Ms. Davis's unusual behavior, took her to an emergency room, where she was evaluated and admitted to a psychiatric unit. After a day of observation, Ms. Davis was started on an antipsychotic, chlorpromazine, and lithium carbonate. Over the course of about 3 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 6 weeks of hospitalization, she was exhibiting none of the symptoms reported on admission. However, she was noted to be experiencing some mild hypersomnia, sleeping about 10 hours a night; 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 8 months after her discharge, Ms. Davis 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 2 weeks she was readmitted to the hospital with almost the identical symptoms that she had when first admitted.

Ms. Davis 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 1 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.

Ms. Davis'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	**Field Code, Rating, and Notes**
Page A.1:	A1 = 1
	A2 = 1
Page A.5:	A27 = 3 (3 years ago, began to feel depressed)
	A28 = 1
Page A.6:	A29 = 3 (loss of appetite; 10-pound weight loss)
	A30 is checked
	A32 = 3 (trouble falling asleep; waking up too early)
	A33 is checked
	A35 = 1
	A38 = 3 (severe fatigue)
	A39 = 3 (feelings of worthlessness)
	A40 is checked
	A42 = 3 (difficulty concentrating)
Page A.7:	A43 = 1
	A48 = 3 (five symptoms coded "3")
Page A.8:	A49 = 3 (clinically significant)
Page A.9:	A50 = 3 (not due to a GMC or substance/medication)
	A51 = 3 (Criteria A, B, and C coded "3")
	A52 = 21 (age at onset)
	A53 = 01 (number of episodes)
Page A.10:	A54 = 1 (no current euphoric or irritable mood)
Page A.18:	A92 = 3 (3 years ago, became increasingly euphoric and irritable)
	A93 and A94 checked
	A95 = 3 (hospitalized)
Page A.19:	A96 = 1
	A97 = 3 (required only 2–3 hours of sleep a night)
	A98 = 3 (overtalkative)
	A99 = 3 (began to experience her thoughts as "racing")
	A100 = 1
	A101 = 1
Page A.20:	A104 = 1
	A105 = 3 (three symptoms coded "3")
Page A.21:	A106 = 3 (hospitalized)
Page A.22:	A107 = 3 (not due to a GMC or substance/medication)
	A108 = 3 (Criteria A, B, C, and D coded "3")
	A109 = 21 (age at onset)
Page A.37:	A172 not checked; A173 = 1

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)
Page B.2:	B3 = 1
	B4 = 3 ("hole in her head")
	B5–B7 = 1

Page B.3: B8 = 1
B9 = 3 (radar messages could control her thoughts)
B10 = 3 (alien thoughts from other people were intruding themselves)
B11–B12 = 1
B13 = 3 (believed her thoughts could be read by other people around her)
Page B.4: B14 = 3 (bizarre content)
B15 = 0 (no delusions present in past week)
B16 = 3 (heard voices)
Page B.5: B17–B21 = 1
B22 = 0 (no hallucinations in past week)
Page B.6: B23 not checked; B24 = 1; B25 = 0 (not present); B26 = 1
Page B.7: B27–B35 = 1
Page B.8: B36–B38 = 1; B39 = 0 (not present); B40 = 1
Page B.9: B42 = 1; B44 = 0 (not present)

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 explained by Psychotic Disorder)
D4 = 1 (Most Recent Episode Manic)
Page D.4: D11 = 1 (not Rapid Cycling)
D12 = 1 (fewer than two MDEs)
D13 = 3 (two Manic Episodes)
D14 not checked
D15 = 1
Page D.14: D42 = 1
D43 = 012 (number of months since last in mood episode)
D44 = 2 (In Full Remission)
D45 = 21 (age at onset)

SCID DX: BIPOLAR DISORDER, IN FULL REMISSION

APPENDIX D: EVALUATION FORM FOR THE 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	**Excel-lent**	**Very good**	**OK**	**Just pass-ing**	**Needs retrain-ing**	**Not applic-able**
1. Established and maintained rapport with subject	5	4	3	2	1	n/a
2. Explained purpose of interview	5	4	3	2	1	n/a
3. Handled subject's questions adequately	5	4	3	2	1	n/a
4. Recognized and dealt with subject's emotional responses during the interview (e.g., anger, tearfulness)	5	4	3	2	1	n/a
II. Obtaining Diagnostic Information						
1. Elicited enough information in the Overview to understand the context and development of the problem	5	4	3	2	1	n/a
2. Elicited adequate treatment history in Overview	5	4	3	2	1	n/a
3. Followed structure of the SCID whenever possible	5	4	3	2	1	n/a
4. Elicited a description of each symptom in subject's own words	5	4	3	2	1	n/a
5. Obtained enough information to make judgments on each item	5	4	3	2	1	n/a
6. Modified questions when necessary to use language that was clear to subject	5	4	3	2	1	n/a
7. Modified questions when necessary to take into account information already obtained	5	4	3	2	1	n/a
8. Resolved contradictions in subject's story	5	4	3	2	1	n/a
9. Followed skip instructions correctly	5	4	3	2	1	n/a

	Excel-lent	Very good	OK	Just pass-ing	Needs retrain-ing	Not applic-able
10. Appropriately skipped to sections to consider general medical or substance etiologies	5	4	3	2	1	n/a
11. Focused interview on time period under consideration (e.g., worst time during episode)	5	4	3	2	1	n/a
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)	5	4	3	2	1	n/a
13. Helped rambling subject to focus on the issue under consideration	5	4	3	2	1	n/a
14. Completed interview in a reasonable period of time (may vary from 45 minutes to 90 minutes, depending on complexity of history)	5	4	3	2	1	n/a