AWARD NUMBER: W81XWH-14-1-0570

TITLE: A Nonpharmacologic Method for Enhancing Sleep in PTSD

PRINCIPAL INVESTIGATOR: Dr. William D. "Scott" Killgore

CONTRACTING ORGANIZATION: University of Arizona
Tucson, AZ 85719-4824

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Fort Detrick, Maryland 21702-5012

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Since 2001, more than 2 million U.S. military personnel have deployed into Iraq and Afghanistan. Recent estimates suggest that between 17-20% of soldiers returning from these conflicts meet criteria for posttraumatic stress disorder (PTSD) upon their return. Notably, sleep disturbance is one of the primary complaints of combat-related PTSD patients. Recent evidence suggests that sleep may play a critical role in the ability to effectively extinguish conditioned fear responses and is necessary for consolidating positively valenced emotional memories. Furthermore, many PTSD patients do not respond to currently available treatments, and sleep disturbance is a frequent residual symptom even among those patients who do respond. Thus, sleep disturbance, as a symptom of PTSD, may lead to a vicious circle that prevents full resolution of the conditioned fear responses, sustaining continuation of the disorder. Thus, rather than conceptualizing sleep problems as a secondary effect of PTSD, a novel approach would involve directly targeting and ameliorating the sleep problems, potentially leading to improved emotional regulation and symptom reduction. Although pharmacologic treatments for sleep problems exist, an alternative non-pharmacologic method to improve sleep is to phase shift and strengthen the circadian entrainment. Bright light therapy (BLT), particularly in the blue wavelength, is an effective treatment for sleep and mood disorders, and is thought to exert its effects through suppression of hypothalamic melatonin production. Although preliminary data support the efficacy of BL therapy in treating PTSD, comprehensive randomized placebo-controlled trials are needed. This project aims to address such needs.
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1. **INTRODUCTION:**

Sleep disturbance is nearly ubiquitous among individuals suffering from PTSD and is a major problem among Service members returning from combat deployments. In fact, sleep problems appear to be the most prevalent complaint of individuals with PTSD [11], and may contribute significantly to the persistence and severity of the disorder [12-14]. Recent evidence suggests that adequate restorative sleep may a crucial component of the ability to generalize fear extinction learning, and ultimately may be a key feature in the process of recovery from PTSD [32]. This study aims to test a novel, inexpensive, and easy to use non-pharmacologic approach to improving sleep among individuals with PTSD. Specifically, this study will evaluate the effectiveness of a blue-wavelength light therapy (BLT) for improving sleep compared to an amber light placebo device among those with a diagnosis of PTSD. There is convincing evidence that BLT has therapeutic effects on anxiety and depression [70], and has strong effects on the normal circadian rhythm of alertness and sleep-wake cycles. These features are all central to the symptomatology of PTSD, yet no published studies have examined the effects of BLT on PTSD outcome. For this study, two groups of participants (45 active treatment; 45 placebo) with PTSD will complete two comprehensive sessions including neurobehavioral assessments, repeated polysomnographic sleep studies, and neuroimaging sessions separated by 6 weeks of actigraphically monitored at home treatment. During the intervening 6 weeks, participants will be randomly assigned to receive 30 minutes of daily morning blue light therapy (BL) or an amber light placebo treatment (PL). Sleep quality and quantity will be measured using subjective reports, objective actigraph readings, and polysomnography. Globally, we hypothesize BL will improve sleep quality and quantity relative to PL, and these improvements will be associated with improvements in neurocognitive and brain function. If the BL treatment is demonstrated as effective, this approach would be readily available for nearly immediate large-scale implementation, as the devices have been widely used for years in other contexts, are already safety tested, and commercially available from several manufacturers for a very low cost. Thus, the impact of this research on treating PTSD would be high and immediate.

2. **KEYWORDS:** trauma, anxiety, stress, depression, nightmares, irritability, light therapy, veteran, military, assault, combat, fMRI, hyperarousal, posttraumatic stress disorder, neuroimaging, flashbacks

3. **ACCOMPLISHMENTS:**
What were the major goals of the project?

According to the Statement of Work (SOW), the following major tasks were proposed:

Major Task 1: Prepare Regulatory Documents and Research Protocol (Y1: Q1)
   Completed: 22 OCT 2014

Major Task 2: Acquire necessary materials and equipment (Y1: Q1-2)
   Completed: FEB 2015

Major Task 3: Hire and Train Study Staff (Y1: Q2)
   Completed: 25 MAY 2015

Major Task 4: Collect Data (Y1: Q3-4, Y2, Y3, Y4)
   In progress: During this reporting period, a total of 13 individuals were preliminarily enrolled into the study. Once enrolled into the study, trained doctoral staff further considered these individuals for inclusion in the study but could not guarantee such inclusion, as the inclusion criteria for the study are stringent and can only be confirmed once the individuals interested in the study partake in a comprehensive screening interview. Of the 13 individuals who completed such an interview, 3 were deemed eligible to further continue in the study. Two of those three individuals have since successfully completed all study related activities. The third of those individuals was removed from the study due to failure to appear at multiple appointments and lack of adherence to study procedures and protocols.

Major Task 5: Analyze and Report Data (Y4: Q3-4)
   This goal is forthcoming; data analysis was not anticipated during the current reporting period.

What was accomplished under these goals?

1) Major Activities: As outlined in quarterly reports submitted for Year 1 of this project, the majority of the work completed has been largely preparatory and quality control-related, with a later focus on participant enrollment and data collection. Preparatory work involved hiring new Research Technicians and recruiting several undergraduate volunteer Research Assistants, and ensuring that all personnel were fully trained on all laboratory procedures and study specific procedures. All equipment required for use in the study was acquired early on in Year 1, including goLITE devices, Actiwatch Spectrum Pros, Fear Conditioning equipment, Zephyr Biopatches, WATTsUp meters, and various assessments and scales. A specialist in the use of the fear conditioning equipment was contracted to conduct a 2-day on-site workshop in the use of the fear conditioning system and basic data analysis. In addition,
computer hardware and software were obtained and checked for optimal use and ability to yield valid data. An online platform for data management, RedCap, was outfitted for the purposes of this study and extensively tested and refined to meet the study’s needs after practice sessions were run and weaknesses identified. Further, fMRI scan sequences were built and tested multiple times in practice runs. Data obtained from each of these practice iterations was processed for use and sequences were continually refined until the resulting product was suited for the analyses planned.

A key component of this project is the use of the fear-conditioning/extinction learning paradigm. The paradigm involves conditioning a mild fear response to various colored stimuli in a particular context using a mild electric shock to the finger. After consultation with our colleagues at Harvard who developed the initial fear-conditioning paradigm, we decided to modify the stimuli from the original version so that they would be more memorable and more relevant to a military context. Specifically, instead of conditioning participants to fear a specific colored desk-lamp in a particular office context, we re-created the stimuli to involve fear conditioning of specific colored vehicles in actual scenes from Iraq and Afghanistan. We believe these will have more external validity. Figure 1 shows the original stimuli developed by Mohammed Milad and colleagues (1A) and the revised stimuli used for the present study (1B). Figure 2 shows the fear conditioning set up.

**A) Original Milad Stimuli**

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**B) Revised Iraq/Afghanistan Stimuli**

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2) **Specific Objectives:** The primary objectives were to prepare the regulatory documents and research protocol, acquire necessary materials and equipment, hire and train study staff, and begin data collection. We are on track and have accomplished all of these specific objectives.

3) **Significant Results/Key Outcomes:** As of the time of this report, 2 participants have completed all aspects of the study, including the baseline neuroimaging, conditioning, polysomnographic sleep testing, and psychological evaluation, 6-weeks of treatment with the blue or amber device, and post-treatment assessment. The sample size is currently too small for meaningful statistical analysis, so we present preliminary descriptions of data below simply to demonstrate feasibility of our current procedures.

**Sleep Diaries:** A key component of the project involves daily monitoring of sleep. Part

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**Fear Conditioning Stimuli**

**Skin Conductance Measurement**

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**Sleep Diary**

**Decrease in Sleep Onset Latency**

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**Blue Light Subjective Sleep Onset Latency Average**

Baseline - Post Treatment

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of this is accomplished via an online sleep diary that is completed daily. Thus far, we have only run 2 participants, but both have complied with this daily log extremely well. As evidence, Figure 3 shows a graph of the mean self-reported sleep onset of these two participants between the baseline and post-treatment sessions. Overall, both participants showed a decline in the time taken to fall asleep.

**Actigraphic Monitoring:** Sleep is also being monitored by actigraphy. We are using the Actiwatch Spectrum Pro device, which allows collection of sleep and activity levels, as well as light exposure in three wavelengths. As shown in Figure 4 below, we are able to examine overall sleep and light values at any timepoint during the study, in this case the figure compares sleep during the baseline week versus the post-treatment week.
Functional MRI: Our study is also utilizing a number of MRI methods. For example, we are collecting functional MRI data during a “negative anticipation” task whereby the participant waits for a potentially aversive stimulus to appear on the screen. The scan measures the response within the insular cortex during the anticipation period. As shown in the figure, this participant showed reduction in insular activation at post treatment.

**Negative Anticipation**

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<td>![Pre-Tx Image]</td>
<td>![Post-Tx Image]</td>
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- **What opportunities for training and professional development has the project provided?**
  One of the Postdoctoral Fellows assigned to the project, Dr. Alkozei, attended a workshop to refine her knowledge pertaining to administration of the Structured Clinical Interview for DSM-V (SCID-5), a required component of the screening process for this project. Subsequent to this, Dr. Alkozei hosted in-lab training sessions for other Postdoctoral Fellows assigned to the project to ensure reliable administration and scoring of this instrument. Additionally, this postdoctoral fellow also attended a week-long training program in the use of Statistical Parametric Mapping (SPM12) neuroimaging analysis software in Boston, MA, and a second multi-day workshop on functional MRI data analysis in Boulder, CO. In addition, all project staff and personnel underwent comprehensive training in proper triage for individuals who are identified as expressing a propensity for suicide during their participation in the study. Training in this required attendance at two training sessions hosted
by the Co-PI, Dr. Haynes. Dr. Haynes met one-on-one with each staff member at the completion of these training sessions to ensure uniform understanding of objectives covered during these trainings. One of our Research Technicians was sent to a 2-day workshop in Scottsdale, AZ to learn advanced polysomnography and sleep scoring skills, which she was then able to bring back to train other members of the lab. Lastly, the PI and four of the project’s personnel attended the Associated Professional Sleep Societies Meeting held in Seattle, WA in June of 2015 to learn of emergent research of interest to sleep disorders and non-pharmacologic therapies, as they relate to the project.

- **How were the results disseminated to communities of interest?**
  Nothing to report. The project is still too early in its course to allow analysis and reporting of data.

- **What do you plan to do during the next reporting period to accomplish the goals?**
  The forthcoming reporting period will be utilized to further bolster recruitment efforts and to continue enrolling and collecting data from those individuals whom are eligible to participate in the study. During year 1 of the project, recruitment efforts were largely focused to the Tucson, AZ metropolitan area, with little extension beyond these parameters. In the next year, we have plans to begin advertising in the greater Phoenix metropolitan area and other cities within the state of Arizona. Additional radio and television advertisements will be utilized, and we are now planning to start placing ads on the local bus system to further assist with these recruitment goals.

4. **IMPACT:**

- **What was the impact on the development of the principal discipline(s) of the project?**
  Nothing to report.

- **What was the impact on other disciplines?**
  Nothing to report.

- **What was the impact on technology transfer?**
  Nothing to report.

- **What was the impact on society beyond science and technology?**
  Nothing to report.

5. **CHANGES/PROBLEMS:**

- Changes in approach and reasons for change
As mentioned in greater detail below, enrollment barriers were encountered early on in the recruitment phase of the study. After a brief review of the specific barriers that prevented potential subjects from being enrolled into the study, it was revealed that our guidelines pertaining to substance use were too stringent to obtain the sample size required for the project. As a result, a protocol amendment was submitted to the local IRB authority and, subsequently, to HRPO, allowing inclusion of individuals who were identified as having used substances such as marijuana in the past. As part of this amendment, instruments were added to the protocol to allow additional data collection regarding past and present substance use to provide better statistical control during statistical analysis. These changes were submitted to HRPO on 14 AUG 2015 and are awaiting approval. Additionally, the PI raised this issue during the In Progress Review (IPR) on 9 SEP 2015.

- **Actual or anticipated problems or delays and actions or plans to resolve them**

  The only significant problem encountered during this reporting period pertained exclusively to participant recruitment. As the study seeks to recruit and enroll participants meeting a very stringent eligibility criteria, we found in our earlier recruitment efforts that it was very difficult to make contact with the population of interest and, further, to identify individuals within the population who met all of the eligibility criteria. After several failed attempts to enroll a substantial number of individuals into the study, enrollment requirements pertaining to substance use were adjusted to a more relaxed degree representative of the habits of the population of interest and questions and instruments added to the protocol to allow study staff to collect information to allow for covariance of substance use within these populations. It is of note that any individuals who had a previous or current history of substance abuse have not been permitted to enroll in the study to control for potential confounds due to abuse versus use. All of these changes were submitted in an amendment to HRPO on 14 AUG 2015 and are awaiting approval prior to their implementation.

- **Changes that had a significant impact on expenditures**

  During this reporting period, no changes were experienced that translated into an increase in our expenditures.

- **Significant changes in use or care of human subjects, vertebrate animals, biohazards, and/or select agents**

  No significant changes in use or care of human subjects to report.

6. **PRODUCTS:**
Nothing to report

7. PARTICIPANTS & OTHER COLLABORATING ORGANIZATIONS

- What individuals have worked on the project?

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<tr>
<th>Name:</th>
<th>William D. “Scott” Killgore, Ph.D.</th>
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<td>Project Role:</td>
<td>Principal Investigator</td>
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<tr>
<td>Researcher Identifier (e.g. ORCID ID):</td>
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<td>Dr. Killgore acts as Principal Investigator for the project, overseeing operations and scientific aims, and acting as primary consultant for study-related changes and activities.</td>
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<td>Funding Support:</td>
<td>Department of Defense Awards W81XWH-14-01-0571, W81XWH-14-01-0570, and W81XWH-12-01-0386</td>
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<th>Name:</th>
<th>Ted Trouard, Ph.D.</th>
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<tr>
<td>Researcher Identifier (e.g. ORCID ID):</td>
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<td>Dr. Trouard has acted as a consultant for the development and refinement of fMRI scan sequences utilized in the project</td>
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<td>Dr. Parthasarathy acts as a consultant for all polysomnography (PSG) and sleep-related aspects of the study. Additionally, he assists in providing resources for the scoring of collect PSG data.</td>
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<tr>
<td>Name</td>
<td>Patricia Haynes, Ph.D.</td>
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<td>Dr. Haynes has assisted in training project personnel on proper administration of various instruments and assessments and has acted as support for trainings specific to suicide triage.</td>
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<tr>
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<td>Ms. Knight has coordinated project efforts and has assisted with regulatory oversight and quality control checks of daily research activities pertaining to the project.</td>
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<td>Funding Support:</td>
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<th>Name</th>
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<td>Contribution to Project:</td>
<td>Dr. Alkozei has assisted with administering clinical assessments required for the study, in addition to providing training opportunities for other lab members responsible for administering neurocognitive assessments.</td>
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<td>Department of Defense Awards W81XWH-14-01-0571, W81XWH-14-01-0570, and W81XWH-12-01-0386</td>
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<tr>
<td><strong>Aleksandra Klimova, Ph.D.</strong></td>
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<td><strong>Ryan Smith, Ph.D.</strong></td>
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<td><strong>Andrew Fridman</strong></td>
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<td><strong>Sarah Markowski</strong></td>
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<td>Bradley Shane</td>
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<td>Miss McIntosh has been tasked with overseeing proper polysomnography training and scoring for the modified sleep latency test for this project.</td>
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<td>Mr. Singh has assisted with recruitment, scheduling, and data collection for the project. He has also helped with data scoring.</td>
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- **Has there been a change in the active other support of the PD/PI(s) or senior/key personnel since the last reporting period?**
  - Nothing to report
What other organizations were involved as partners?
  Nothing to report

8. SPECIAL REPORTING REQUIREMENTS
  Nothing to report
9. APPENDICES:

<table>
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<tr>
<th>List of Assessments</th>
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<tbody>
<tr>
<td>Copies of Questionnaires &amp; Examples of Computer-Administered Tasks</td>
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<tr>
<td>William D. “Scott” Kilgore, Ph.D. Curriculum Vitae</td>
<td>356</td>
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</table>
A Nonpharmacologic Method for Enhancing Sleep in PTSD

List of Assessments and Computer-Administered Tasks

Structured Clinical Interview for DSM-V (SCID-V)
Edinburgh Handedness Inventory (EHI)
CES (Combat Exposure Scale)
Morningness-Eveningness Questionnaire (MEQ)
Alcohol Use Disorders Identification Test (AUDIT)
Rivermead Post Concussive Symptoms Questionnaire (RPCSQ)
Marijuana Use Questionnaire (MUSE)
Wide Range Achievement Test 4 (WRAT 4)
Wechsler Abbreviated Scale of Intelligence (WASI-II)
Day of Scan Questionnaire
Psychomotor Vigilance Task (PVT)
Stanford Sleepiness Scale (SSS)
Beck Depression Inventory (BDI-II)
Beck Anxiety Inventory (BAI)
Evaluation of Risk Scale (EVAR)
State Trait Anxiety Inventory (STAI)
Connor-Davidson Resilience Scale (CD RISC)
PTSD Checklist for DSM-V (PCL-5)
Insomnia Severity Index (ISI)
Pittsburgh Sleep Quality Index (PSQI)
Patient Health Questionnaire (PHQ-9)
Disturbing Dreams and Nightmare Severity Index (DDNSI)
Functional Outcomes of Sleep Questionnaire (FOSQ)
Repeated Battery for the Assessment of Neuropsychological Status (RBANS)
Clinician Administered PTSD Scale for DSM-V (CAPS-5)
Balloon Analog Risk Task (BART)
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**SCIZOPHRENI A AND OTHER PSYCHOTIC DISORDERS**

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**SUBSTANCE USE DISORDERS**

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**Lifetime Prevalence**

**Meets Symptomatic Dx. Crit. Past 12 Months**
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<td>P82</td>
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<td></td>
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<td>P84</td>
</tr>
<tr>
<td>41</td>
<td>Body Dysmorphic Disorder *(OPTIONAL) <em>(Opt-G.7/lifetime)(Opt-G.9/past month)</em></td>
<td>?</td>
<td>1</td>
<td>2</td>
<td></td>
<td>3</td>
<td>P85,</td>
</tr>
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<td></td>
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<td>P86</td>
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<td></td>
<td></td>
<td></td>
<td>P88</td>
</tr>
<tr>
<td>43</td>
<td>Excoriation *(Skin-Picking Disorder) *(OPTIONAL) <em>(Opt-G.14/lifetime)(Opt-G.15/past month)</em></td>
<td>?</td>
<td>1</td>
<td>2</td>
<td></td>
<td>3</td>
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<td></td>
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<td></td>
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<td>P90</td>
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</tbody>
</table>

24
### SCID Code Diagnosis

<table>
<thead>
<tr>
<th>SCID Code</th>
<th>Diagnosis</th>
<th>Inadequate Info.</th>
<th>Absent</th>
<th>Sub-threshold</th>
<th>Threshold</th>
<th>Absent</th>
<th>Present</th>
</tr>
</thead>
<tbody>
<tr>
<td>44</td>
<td>Other Specified Obsessive Compulsive and Related Disorder (G.9/lifetime)(G.9/past month)</td>
<td>?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>→ 1</td>
<td>3</td>
</tr>
<tr>
<td>45</td>
<td>Obsessive-Compulsive and Related Disorder Due to Another Medical Condition (G.13/lifetime)(G.13/past month)</td>
<td>?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>→ 1</td>
<td>3</td>
</tr>
<tr>
<td>46</td>
<td>Substance/Medication-Induced Obsessive-Compulsive and Related Disorder (G.16/lifetime) (G.16/past month). Specify substance: _______</td>
<td>?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>→ 1</td>
<td>3</td>
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</tbody>
</table>

### SLEEP-WAKE DISORDERS

<table>
<thead>
<tr>
<th>SCID Code</th>
<th>Diagnosis</th>
<th>Inadequate Info.</th>
<th>Absent</th>
<th>Sub-threshold</th>
<th>Threshold</th>
<th>Absent</th>
<th>Present</th>
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</thead>
<tbody>
<tr>
<td>47</td>
<td>Insomnia Disorder (OPTIONAL) (Opt-H.3/past 3 months)</td>
<td>?</td>
<td>1</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>48</td>
<td>Hypersomnolence Disorder (OPTIONAL) (Opt-H.7/past 3 months)</td>
<td>?</td>
<td>1</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>49</td>
<td>Substance-Induced Sleep Disorder (OPTIONAL) (Opt-H.11) Specify substance: _______</td>
<td>?</td>
<td>1</td>
<td>3</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

### FEEDING AND EATING DISORDERS

<table>
<thead>
<tr>
<th>SCID Code</th>
<th>Diagnosis</th>
<th>Inadequate Info.</th>
<th>Absent</th>
<th>Sub-threshold</th>
<th>Threshold</th>
<th>Absent</th>
<th>Present</th>
</tr>
</thead>
<tbody>
<tr>
<td>50</td>
<td>Anorexia Nervosa (I.1/lifetime) (I.2/past 3 months)</td>
<td>?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>→ 1</td>
<td>3</td>
</tr>
<tr>
<td>51</td>
<td>Bulimia Nervosa (I.5/lifetime) (I.6/past 3 months)</td>
<td>?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>→ 1</td>
<td>3</td>
</tr>
<tr>
<td>52</td>
<td>Binge Eating Disorder (I.8/lifetime)(I.9/past 3 months)</td>
<td>?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>→ 1</td>
<td>3</td>
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</table>

<table>
<thead>
<tr>
<th>SCID Code</th>
<th>Diagnosis</th>
<th>Inadequate Info.</th>
<th>Absent</th>
<th>Sub-threshold</th>
<th>Threshold</th>
<th>Absent</th>
<th>Present</th>
</tr>
</thead>
<tbody>
<tr>
<td>53</td>
<td>Avoidant/Restrictive Food Intake Disorder (OPTIONAL) (Opt-I.3/past month)</td>
<td>?</td>
<td>1</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>54</td>
<td>Other Specified Feeding or Eating Disorder (I.10/lifetime) (I.10/past month)</td>
<td>?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>→ 1</td>
<td>3</td>
</tr>
<tr>
<td>SCID Code</td>
<td>Diagnosis</td>
<td>Inadequate Info</td>
<td>Absent</td>
<td>Sub-threshold</td>
<td>Threshold</td>
<td>Absent</td>
<td>Present</td>
</tr>
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<td>-----------</td>
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<td>---------</td>
</tr>
<tr>
<td><strong>SOMATIC SYMPTOM AND RELATED DISORDERS</strong></td>
<td></td>
<td>Current Only</td>
<td>Meets Symptomatic Dx. Crit. Past 6 Months</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>55</td>
<td>Somatic Symptom Disorder (OPTIONAL) (Opt-J.2/past 6 months)</td>
<td>?</td>
<td></td>
<td>1</td>
<td>3</td>
<td></td>
<td>P111</td>
</tr>
<tr>
<td>56</td>
<td>Illness Anxiety Disorder (OPTIONAL) (Opt-J.4/past 6 months)</td>
<td>?</td>
<td></td>
<td>1</td>
<td>3</td>
<td></td>
<td>P112</td>
</tr>
<tr>
<td><strong>EXTERNALIZING DISORDERS</strong></td>
<td></td>
<td>Current Only</td>
<td>Meets Symptomatic Dx. Crit. Past 12 Months</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>57</td>
<td>Adult Attention-deficit/ Hyperactivity Disorder (K.5/past 6 months)</td>
<td>?</td>
<td></td>
<td>1</td>
<td>3</td>
<td></td>
<td>P113</td>
</tr>
<tr>
<td>58</td>
<td>Intermittent Explosive Disorder (OPTIONAL) (Opt-K.4/past 12 months)</td>
<td>?</td>
<td></td>
<td>1</td>
<td>3</td>
<td></td>
<td>P114</td>
</tr>
<tr>
<td>59</td>
<td>Gambling Disorder (OPTIONAL) (Opt-K.7/past 12 months)</td>
<td>?</td>
<td></td>
<td>1</td>
<td>3</td>
<td></td>
<td>P115</td>
</tr>
<tr>
<td><strong>TRAUMA- AND STRESSOR-RELATED DISORDERS</strong></td>
<td></td>
<td>Current Only</td>
<td>Meets Symptomatic Dx. Crit. Past Month</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60</td>
<td>Acute Stress Disorder (L.10/past month)</td>
<td>?</td>
<td></td>
<td>1</td>
<td>3</td>
<td></td>
<td>P116</td>
</tr>
<tr>
<td>61</td>
<td>Posttraumatic Stress Disorder (L.18/lifetime)(L.18/past month)</td>
<td>?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>62</td>
<td>Adjustment Disorder (L.22/past 6 months)</td>
<td>?</td>
<td></td>
<td>1</td>
<td>3</td>
<td></td>
<td>P119</td>
</tr>
<tr>
<td>63</td>
<td>Other Specified Trauma- and Stressor-Related Disorder (L.23/lifetime)(L.23/past month)</td>
<td>?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>64</td>
<td><strong>OTHER DSM-5 DISORDER:</strong> Specify: __________________________</td>
<td>?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>
PRINCIPAL DIAGNOSIS (i.e., the disorder that is [or should be] the main focus of current clinical attention).

Enter SCID Code number from scoresheet for principal diagnosis: __ __

Note: Code 00 if no current mental disorder. Code 99 if unknown.

INTERVIEWER’S DIAGNOSES, IF DIFFERENT FROM SCID DIAGNOSES:

____________________________________________________________________________________

PROVISIONAL DIAGNOSIS (i.e., the disorder(s) that need more information in order to be ruled out).

SOCIAL AND OCCUPATIONAL FUNCTIONING ASSESSMENT SCALE (SOFAS)

Consider psychological, social, and occupational functioning on a continuum from excellent functioning to grossly impaired functioning. Include impairments in functioning due to physical limitations, as well as those due to mental impairments. To be counted, impairment must be a direct consequence of mental and physical health problems; the effects of lack of opportunity and other environmental limitations are not be to considered.

CODE (Note: Use intermediate codes when appropriate, e.g., 45, 68, 72).

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Superior functioning in a wide range of activities.</td>
</tr>
<tr>
<td>91</td>
<td>Good functioning in all areas, occupationally and socially effective.</td>
</tr>
<tr>
<td>90</td>
<td>No more than a slight impairment in social, occupational, or school functioning (e.g., infrequent interpersonal conflict, temporarily falling behind in schoolwork).</td>
</tr>
<tr>
<td>81</td>
<td>Some difficulty in social, occupational, or school functioning, but generally functioning well, has some meaningful interpersonal relationships.</td>
</tr>
<tr>
<td>80</td>
<td>Moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or coworkers).</td>
</tr>
<tr>
<td>71</td>
<td>Serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).</td>
</tr>
<tr>
<td>70</td>
<td>Major impairment in several areas, such as work or school, family relations, (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).</td>
</tr>
<tr>
<td>61</td>
<td>Inability to function in almost all areas (e.g., stays in bed all day; no job, home, or friends).</td>
</tr>
<tr>
<td>60</td>
<td>Occasionally fails to maintain minimal personal hygiene; unable to function independently.</td>
</tr>
<tr>
<td>51</td>
<td>Persistent inability to maintain minimal personal hygiene. Unable to function without harming self or others or without considerable external support (e.g., nursing care and supervision).</td>
</tr>
<tr>
<td>50</td>
<td>Inadequate information.</td>
</tr>
</tbody>
</table>
Nonpatient Overview

I’m going to be asking you about problems or difficulties you may have had, and I’ll be making some notes as we go along. Do you have any questions before we begin?

NOTE: Any current suicidal thoughts, plans, or actions should be thoroughly assessed by the clinician and action taken if necessary.

Demographic Data

GENDER: 1 Male  2 Female  3 Other (e.g., transgendered)

What’s your date of birth?

DOB: _____ _____ _____ AGE: ___ ___

Are you married?

IF NO: Do you live with someone as if you are married?

IF NO: Were you ever married?

How long have you been (MARITAL STATUS)?

IF EVER MARRIED: How many times have you been married?

Do you have any children?

IF YES: How many? (What are their ages?)

With whom do you live? (How many children under the age of 18 live in your household?)

In what city, town, or neighborhood do you live?

In what kind of place do you live? (A house, an apartment, a shelter, a halfway house, or some other living arrangement? Are you homeless?)

Education and Work History

How far did you go in school?

EDUCATION: 1 Grade 6 or less  2 Grades 7 to 12 (without graduating high school)  3 Graduated high school or high school equivalent  4 Part college/trade school  5 Graduated 2-year college or trade school  6 Graduated 4-year college  7 Part graduate/professional school  8 Completed graduate/professional school

IF FAILED TO COMPLETE A PROGRAM IN WHICH THEY WERE ENROLLED: Why did you leave?

What kind of work do you do? (Do you work outside of your home?)
Education and Work History (continued)

Have you always done that kind of work?

**IF NO:** What other kind of work have you done in the past?

What’s the longest you’ve worked at one place?

Are you currently employed (getting paid)?

**IF YES:** Do you work part-time or full-time?

**IF PART-TIME:** How many hours do you typically work each week? (Why do you work part-time instead of full-time?)

**IF NO:** Why is that? When was the last time you worked? How are you supporting yourself now?

**IF DISABLED:** Are you currently receiving disability payments? What are you receiving disability for?

**IF EMPLOYED:** How long have you worked at your current job?

**IF LESS THAN 6 MONTHS:** Why did you leave your last job?

**IF UNKNOWN:** Has there ever been a period of time when you were unable to work or go to school?

**IF YES:** Why was that?

Have you ever been arrested, involved in a lawsuit, or had other legal trouble?

Current and Past Periods of Psychopathology

*NOTE: FOR A COMPLICATED HX, USE THE LIFE CHART ON PAGE 7.*

Have you ever seen anybody for emotional or psychiatric problems?

**IF YES:** What was that for? (What treatment did you get? Any medications? When was that? When was the first time you ever saw someone for emotional or psychiatric problems?)

**IF NO:** Was there ever a time when you, or someone else, thought you should see someone because of the way you were feeling or acting? (Tell me more.)

Have you ever seen anybody for problems with alcohol or drugs?

**IF YES:** What was that for? (What treatment[s] did you get? Any medications? When was that?)

Have you ever attended a self-help group, like Alcoholics Anonymous, Gamblers Anonymous, or Overeaters Anonymous?

**IF YES:** What was that for? When was that?
Hospitalization History

Have you ever been a patient in a psychiatric hospital?  

**IF YES:**  What was that for?  (How many times?)  

**IF AN INADEQUATE ANSWER IS GIVEN, CHALLENGE GENTLY:**  e.g.,  *Wasn't there something else?  People don't usually go to psychiatric hospitals just because they are tired or nervous.*

Have you ever been in a hospital for treatment of a medical problem?  

**IF YES:**  What was that for?

Thinking back over your whole life, when were you the most upset?  (Why?  What was that like?  How were you feeling?)

<table>
<thead>
<tr>
<th>Number of previous hospitalizations (Do not include transfers):</th>
</tr>
</thead>
<tbody>
<tr>
<td>___  ____________________________________________________</td>
</tr>
<tr>
<td>___  ____________________________________________________</td>
</tr>
<tr>
<td>___  ____________________________________________________</td>
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<tr>
<td>___  ____________________________________________________</td>
</tr>
<tr>
<td>___  ____________________________________________________</td>
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<tr>
<td>___  ____________________________________________________</td>
</tr>
</tbody>
</table>

Suicidal Ideation and Behavior

**CHECK FOR THOUGHTS:**  Have you ever wished you were dead or wished you could go to sleep and not wake up?  (Tell me about that.)

**IF NO:**  SKIP TO NEXT PAGE,  *SUICIDE ATTEMPT*

**IF YES:**  Did you have any of these thoughts in the past week (including today)?

**IF NO:**  SKIP TO NEXT PAGE,  *SUICIDE ATTEMPT*

**IF YES:**  CHECK FOR INTENT:  Have you had a strong urge to kill yourself at any point during the past week?  (Tell me about that.)  In the past week, did you have any intention of attempting suicide?  (Tell me about that.)

**CHECK FOR PLAN AND METHOD:**  In the past week, have you thought about how you might actually do it?  (Tell me about what you were thinking of doing.)  Have you thought about what you would need to do to carry this out?  (Tell me about that.  Do you have the means to do this?)

**RECORD ANY HISTORY OF SUICIDAL THOUGHTS OR BEHAVIORS, INCLUDING IN THE PAST WEEK:**

Check if:

___ Suicidal Ideation lifetime  
___ Suicidal Ideation past week  
___ with suicide intent  
___ with suicide plan  
___ with access to chosen method
*Suicide Attempt*

**CHECK FOR ATTEMPT:** Have you ever tried to kill yourself?

IF NO: Have you ever done anything to harm yourself?

IF NO: GO TO *OTHER CURRENT PROBLEMS,* BELOW.

IF YES TO EITHER OF ABOVE: What did you do? (Tell me what happened.) Were you trying to end your life?

IF MORE THAN ONE ATTEMPT: Which attempt had the most severe medical consequences (going to emergency department, needing hospitalization, requiring ICU)?

Have you made any suicide attempts in the past week (including today)?

Check if:

___ Suicide attempt lifetime
___ Suicide attempt past week

Other Current Problems

Have you had any other problems in the past month? (How are things going at work, at home, and with other people?)

What has your mood been like?

How has your physical health been? (Have you had any medical problems?)

Do you take any medication, vitamins, nutritional supplements, or natural health remedies (other than those you’ve already told me about?)

IF YES: How much and how often do you take (MEDICATION)? (Has there been any change in the amount you have been taking?)

In the past month, how much have you been drinking?

When you drink, who are you usually with? (Are you usually alone or out with other people?)

In the past month, have you been using any illegal or recreational drugs? How about taking more of your prescription drugs than was prescribed or running out early?

How have you been spending your free time? Who do you spend time with?

Lifetime Alcohol and Drug Use

Now I would like to ask you some more about your alcohol use over your lifetime.

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?

Have you ever had a time when anyone objected to your drinking?
Now I’d like to ask you about your use of drugs or medicines over your lifetime.

**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

<table>
<thead>
<tr>
<th>Drug Class</th>
<th>LIFETIME</th>
<th>PAST YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sedatives-hypnotics-anxiolytics</td>
<td>1 3 1 3</td>
<td>ONP15</td>
</tr>
<tr>
<td>Cannabis</td>
<td>1 3 1 3</td>
<td>ONP16</td>
</tr>
<tr>
<td>Stimulants</td>
<td>1 3 1 3</td>
<td>ONP17</td>
</tr>
<tr>
<td>Opioids</td>
<td>1 3 1 3</td>
<td>ONP18</td>
</tr>
</tbody>
</table>

**FOR EACH DRUG CLASS IN WHICH SUBJECT ACKNOWLEDGES USE OF A DRUG FROM THAT CLASS, ASK THE FOLLOWING QUESTIONS:**

**Over your lifetime, when were you taking (SUBSTANCE) the most? How long did that period last? During that time, how often were you taking it? How much were you using?**

**Have you ever had a time when your use of (SUBSTANCE) caused problems for you?**

**IF YES:** How about in the past 12 months?

**Have you ever had a time when anyone objected to your use of (SUBSTANCE)?**

**IF YES:** How about in the past 12 months?

**IF ILLICIT OR RECREATIONAL DRUG:** Have you ever used (SUBSTANCE) at least six times in a 12 month period?

**IF YES:** How about in the past 12 months?

**IF PRESCRIBED OR OTC MEDICATION AND UNKNOWN:** Did you ever get hooked or become dependent on (PRESCRIBED/OTC DRUG)? Did you ever take more of it than was prescribed (or, for OTC was directed) or run out of your prescription early? (Did you ever have to go to more than one doctor to make sure you didn’t run out?)

**IF YES:** How about in the past 12 months?
<table>
<thead>
<tr>
<th>Question</th>
<th>Class</th>
<th>ONP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever used any drugs to “trip” or heighten your senses?</td>
<td>Hallucinogens:</td>
<td>1</td>
</tr>
<tr>
<td>(Drugs like LSD, “acid,” peyote, mescaline, psilocybin, Ecstasy [MDMA, “molly”], bath salts, DMT or other hallucinogens?)</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Have you ever used PCP (“angel dust,” “peace pill”) or ketamine (“Special K,” “Vitamin K”)?</td>
<td>Phencyclidine and Related Substances:</td>
<td>1</td>
</tr>
<tr>
<td>Have you ever used glue, paint, or correction fluid, gasoline, or other inhalants to get high?</td>
<td>Inhalants:</td>
<td>1</td>
</tr>
<tr>
<td>NOTE: Nitrous oxide, and amyl-, butyl-, or Isobutyl/nitrite are not inhalants but are classified as Other (or Unknown) Substance Use Disorder (below).</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>What about other drugs, like anabolic steroids, nitrous oxide (laughing gas, “whippets”), nitrites (amyl nitrite, butyl nitrite, “poppers,” “snappers”), diet pills (phentermine), or over-the-counter medicine for allergies, colds, cough, or sleep?</td>
<td>Other (or Unknown):</td>
<td>1</td>
</tr>
</tbody>
</table>

**FOR EACH DRUG CLASS IN WHICH SUBJECT ACKNOWLEDGES USE OF A DRUG FROM THAT CLASS, ASK THE FOLLOWING QUESTIONS:**

- Over your lifetime, when were you taking (SUBSTANCE) the most? How long did that period last? During that time, how often were you taking it? How much were you using?
- Have you ever had a time when your use of (SUBSTANCE) caused problems for you?
  - IF YES: How about in the past 12 months?
- Have you ever had a time when anyone objected to your use of (SUBSTANCE)?
  - IF YES: How about in the past 12 months?
  - IF ILLICIT OR RECREATIONAL DRUG: Have you ever used (SUBSTANCE) at least six times in a 12 month period?
    - IF YES: How about in the past 12 months?
  - IF PRESCRIBED OR OTC MEDICATION AND UNKNOWN: Did you ever get hooked or become dependent on (PRESCRIBED/OTC DRUG)? Did you ever take more of it than was prescribed (or, for OTC was directed) or run out of your prescription early? (Did you ever have to go to more than one doctor to make sure you didn’t run out?)
    - IF YES: How about in the past 12 months?
**THE LIFE CHART (BELOW) MAY BE USED AT ANY POINT IN THE OVERVIEW TO RECORD THE DETAILS OF A COMPLICATED HISTORY.**

**LIFE CHART**

<table>
<thead>
<tr>
<th>Age (or date)</th>
<th>Description (symptoms, triggering events)</th>
<th>Treatment</th>
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*RETURN TO OVERVIEW PAGE 3, *HOSPITALIZATION HISTORY* TO CONTINUE WITH OVERVIEW QUESTIONS.*
**SCID Screening Module (including optional disorders)**

Now I want to ask you some more specific questions about problems you may have had. We’ll go into more detail about them later.

1. 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?  
   (screening for panic attacks)  
   
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<th>NO</th>
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<td>CIRCLE &quot;NO&quot; ON F.1</td>
<td>CIRCLE &quot;YES&quot; ON F.1</td>
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2. 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?  
   (screening for Agoraphobia)  
   
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<td>CIRCLE &quot;NO&quot; ON F.8</td>
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3. Have you been especially nervous or anxious in social situations like having a conversation or meeting unfamiliar people?  
   (screening for Social Anxiety Disorder)  
   
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<td>CIRCLE &quot;YES&quot; ON 1st ITEM, F.14</td>
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4. Is there anything that you have been afraid to do or felt very uncomfortable doing in front of other people, like speaking, eating, writing, or using a public bathroom?  
   (screening for Social Anxiety Disorder)  
   
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<td>CIRCLE &quot;YES&quot; ON 2nd ITEM, F.14</td>
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5. Are there any other things that have made you especially anxious or afraid, like flying, seeing blood, getting a shot, heights, closed places, or certain kinds of animals or insects?  
   (screening for Specific Phobia)  
   
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6. Over the last several months have you been feeling anxious and worried for a lot of the time?  
   (screening for current Generalized Anxiety Disorder)  
   
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7. **ASK ONLY IF PREVIOUS QUESTION ANSWERED NO:** Have you ever had a time lasting at least several months in which you were feeling anxious and worried for a lot of the time?  
   (screening for past Generalized Anxiety Disorder)  
   
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<td>CIRCLE &quot;NO&quot; ON F.27</td>
<td>CIRCLE &quot;YES&quot; ON F.27</td>
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</table>

7a. In the past 6 months, since (6 MONTHS AGO), have you been especially anxious about being separated from people you’re attached to (like your parents, children, or partner)?  
   (screening for current Separation Anxiety Disorder)  
   
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<td>CIRCLE &quot;NO&quot; ON Opt-F.1</td>
<td>CIRCLE &quot;YES&quot; ON Opt-F.1</td>
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</table>
8. **Have you ever been bothered with 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?**

   (screening for obsessions in Obsessive-Compulsive Disorder)

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<td>CIRCLE &quot;YES&quot; ON 1st ITEM, G.1</td>
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9. **How about having images pop into your head that you didn't want like violent or horrible scenes or something of a sexual nature?**

   (screening for obsessions in Obsessive-Compulsive Disorder)

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<td>CIRCLE &quot;YES&quot; ON 2nd ITEM, G.1</td>
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10. **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?**

    (screening for obsessions in Obsessive-Compulsive Disorder)

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<td>CIRCLE &quot;YES&quot; ON 3rd ITEM, G.1</td>
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11. **Was there ever anything that you had to do over and over again and was hard to resist doing, like washing your hands again and again, repeating something over and over again until it “felt right,” counting up to a certain number, or checking something many times to make sure that you’d done it right?**

    (screening for compulsions in Obsessive-Compulsive Disorder)

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<td>CIRCLE &quot;YES&quot; ON G.2</td>
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11a. **Have you found it difficult to throw out, sell, or give away things?**

    (screening for Hoarding Disorder)

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11b. **Have you been very concerned that there is something wrong with your physical appearance or the way one or more parts of your body looks?**

    (screening for Body Dysmorphic Disorder)

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11c. **Have you ever repeatedly pulled out hair from anywhere on your body other than for cosmetic reasons?**

    (screening for Trichotillomania)

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11d. **Have you ever repeatedly picked at your skin with your fingernails, tweezers, pins, or other objects?**

    (screening for Excoriation Disorder)

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11e. **Over the past 3 months, since (3 MONTHS AGO), has a major concern of yours been that you are not getting enough good sleep or not feeling rested?**

    (screening for current Insomnia Disorder)

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11f. Over the past 3 months, since (3 MONTHS AGO), have you often had days when you were sleepy despite having slept for at least 7 hours?  
(screening for current Hypersomnolence Disorder)  

12. Have you ever had a time when you weighed much less than other people thought you ought to weigh?  
(screening for Anorexia Nervosa)  

13. Have you often had times when your eating was out of control?  
(screening for binge eating in Bulimia Nervosa and Binge Eating Disorder)  

13a. In the past month, since (1 MONTH AGO), have you been uninterested in food in general or have you kept forgetting to eat?  
(screening for current Avoidant/Restrictive Food Intake Disorder)  

13b. In the past month, since (1 MONTH AGO), have you avoided eating a lot of foods because of the way they look or the way they feel in your mouth?  
(screening for current Avoidant/Restrictive Food Intake Disorder)  

13c. In the past month, since (1 MONTH AGO), have you avoided eating a lot of different foods because you are afraid you won't be able to swallow or that you will choke, gag, or throw up?  
(screening for current Avoidant/Restrictive Food Intake Disorder)  

13d. Over the past 6 months, since (6 MONTHS AGO), have you been bothered by any physical symptoms?  
(screening for current Somatic Symptom Disorder)  

13e. Over the past 6 months, since (6 MONTHS AGO), have you spent a lot of time thinking that you have, or will get, a serious disease?  
(screening for current Illness Anxiety Disorder)  

14. Over the past several years, have you often been easily distracted or disorganized?  
(screening for inattention in current Attention-Deficit/Hyperactivity Disorder)
15. **Over the past several years, have you often had a lot of difficulty sitting still or waiting your turn?**

*(screening for hyperactivity/impulsivity in current Attention-Deficit/Hyperactivity Disorder)*

**NO**  
**YES**  

15a. **In the past year, since (1 YEAR AGO), have you frequently lost control of your temper and ended up yelling or getting into arguments with others?**

*(screening for current Intermittent Explosive Disorder)*

**NO**  
**YES**  

15b. **In the past year, since (1 YEAR AGO), 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?**

*(screening for current Intermittent Explosive Disorder)*

**NO**  
**YES**  

15c. **In the past year, since (1 YEAR AGO), have you regularly gambled or regularly bought lottery tickets?**

*(screening for current Gambling Disorder)*

**NO**  
**YES**
A. MOOD EPISODES

NOTE: This module is for evaluating Current and Past Mood Episodes, Cyclothymic Disorder, Persistent Depressive Disorder (Dysthymia), AND Premenstrual Dysphoric Disorder. Bipolar I Disorder, Bipolar II Disorder, Other Specified Bipolar Disorder, Major Depressive Disorder, and Other Specified Depressive Disorder are diagnosed in Module D.

*CURRENT MAJOR DEPRESSIVE EPISODE*

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

Since (1 MONTH AGO), has there been a period of time when you were feeling depressed or down most of the day nearly every day? (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.

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).

FOR THE FOLLOWING QUESTIONS, FOCUS ON THE WORST 2 WEEKS IN THE PAST MONTH (OR ELSE THE PAST 2 WEEKS IF EQUALLY DEPRESSED FOR ENTIRE MONTH).

NOTE: When rating the following items, code “1” if the symptoms are clearly due to a general medical condition (e.g., insomnia due to severe back pain).

IF UNKNOWN: Since (1 MONTH AGO), during which 2-week period would you say you have been doing the worst?

?= inadequate information  1 = absent or false  2 = subthreshold  3 = threshold or true
SCID-RV (for DSM-5®) (Version 1.0.0) Current MDE Mood Episodes w/o Specifiers A.2

During (2-WEEK PERIOD)...

...how has your appetite been? (What about compared to your usual appetite? Have you had to force yourself to eat? Eat [less/more] than usual? Has that been nearly every day? Have you lost or gained any weight? How much?)

IF YES: Have you been trying to [lose/gain] weight?

...how have you been sleeping? (Trouble falling asleep, waking frequently, trouble staying asleep, waking too early, OR sleeping too much? How many hours of sleep [including naps] have you been getting? How many hours of sleep did you typically get before you got [depressed/OWN WORDS]? Has it been nearly every night?)

...have you been so fidgety or restless that you were unable to sit still? What about the opposite—talking more slowly, or moving more slowly than is normal for you, as if you're moving through molasses or mud? (In either instance, has it been so bad that other people have noticed it? What have they noticed? Has that been nearly every day?)

...what has your energy level been like? (Tired all the time? Nearly every day?)

...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: Nearly every day?

...have you had trouble thinking or concentrating? Has it been hard to make decisions about everyday things? (What kinds of things has it been interfering with? Nearly every day?)

3. Significant weight loss when not dieting, or weight gain (e.g., a change of more than 5% of body weight in a month) or decrease or increase in appetite nearly every day. NOTE: in children, consider failure to make expected weight gains.

Check if:

A4 weight loss or decreased appetite
A5 weight gain or increased appetite

4. Insomnia or hypersomnia nearly every day.

Check if:

A7 insomnia
A8 hypersomnia

5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)

NOTE: Consider behavior during the interview.

Check if:

A10 psychomotor agitation
A11 psychomotor retardation

6. Fatigue or loss of energy nearly every day.

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:

A14 worthlessness
A15 inappropriate guilt

8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).

?=inadequate information 1=absent or false 2=subthreshold 3=threshold or true
...have things been so bad that you thought a lot about death or that you would be better off dead? Have you thought about taking your own life?

**IF YES:** Have you done something about it? (What have you done? Have you made a specific plan? Have you taken any action to prepare for it? Have you actually made a suicide attempt?)

9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

NOTE: Code “1” for self-mutilation without suicidal intent.

**Check if:**
- thoughts of own death
- suicidal ideation
- specific plan
- suicide attempt

NOTE: Any current suicidal thoughts, plans, or actions should be thoroughly assessed by the clinician and action taken if necessary.


**IF UNKNOWN:** What effect have (DEPRESSIVE SXS) had on your life?

**ASK THE FOLLOWING QUESTIONS AS NEEDED TO RATE CRITERION B:**

**How have (DEPRESSIVE SXS) affected your relationships or your interactions with other people?** (Has this caused you any problems in your relationships with your family, romantic partner or friends?)

**How have (DEPRESSIVE SXS) affected your work/school?** (How about your attendance at work or school? Did [DEPRESSIVE SXS] make it more difficult to do your work/schoolwork? How have [DEPRESSIVE SXS] affected the quality of your work/schoolwork?)

**How have (DEPRESSIVE SXS) affected your ability to take care of things at home?** How about doing simple everyday things like getting dressed, bathing, or brushing your teeth? What about doing other things that are important to you like religious activities, physical exercise, or hobbies? Have you avoided doing anything because you felt like you weren’t up to it?

**Have (DEPRESSIVE SXS) affected any other important part of your life?**

**IF DOES NOT INTERFERE WITH LIFE:** How much have you been bothered or upset by having (DEPRESSIVE SXS)?

? = inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true
IF UNKNOWN: When did (EPISODE OF DEPRESSION) begin?
Just before this began, were you physically ill?
IF YES: What did the doctor say?
Just before this began, were you using any medications?
IF YES: Any change in the amount you were using?
Just before this began, were you drinking or using any drugs?
C. [Primary Depressive Episode:] The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, medication) or to another medical condition.
IF THERE IS ANY INDICATION THAT THE DEPRESSION MAY BE SECONDARY (I.E., A DIRECT PHYSIOLOGICAL CONSEQUENCE OF GMC OR SUBSTANCE/MEDICATION), GO TO *GMC/SUBSTANCE* A.45, AND RETURN HERE TO MAKE A RATING OF "1" OR "3."

Etiological medical conditions include: stroke, Huntington's disease, Parkinson's disease, traumatic brain injury, Cushing's disease, hypothyroidism, multiple sclerosis, systemic lupus erythematosus.

Etiological substances/medications include: alcohol (I/W), phencyclidine (I), hallucinogens (I), inhalants (I), opioids (I/W), sedative, hypnotics or anxiolytics (I/W), amphetamine and other stimulants (I/W), cocaine (I/W), antiviral agents (etavirenz), cardiovascular agents (clonidine, guanethidine, methyldopa, reserpine), retinoic acid derivatives (isotretinoin), antidepressants, anticonvulsants, anti-migraine agents (triptans), antipsychotics, hormonal agents (corticosteroids, oral contraceptives, gonadotropin-releasing hormone agonists, tamoxifen), smoking cessation agents (varenicline) and immunological agents (interferon).

MAJOR DEPRESSIVE EPISODE CRITERIA A, B, AND C ARE CODED "3."

How many separate times in your life have you been (depressed/OWN WORDS) nearly every day for at least 2 weeks and had several of the symptoms that you described, like (SXS OF CURRENT MDE)?
Total number of Major Depressive Episodes, including current (CODE 99 IF TOO NUMEROUS OR INDISTINCT TO COUNT).
\*PAST MAJOR DEPRESSIVE EPISODE\*

**NOTE:** If currently depressed mood or loss of interest but full criteria are not met for a major depressive episode, substitute the phrase "Has there ever been another time..." in each of the screening questions below.

Have you ever had a period when you were feeling depressed or down most of the day nearly every day? (Did anyone say that you looked sad, down, or depressed?)

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

**IF YES TO EITHER OF ABOVE:** What was that like? When was that? How long did it last? (As long as 2 weeks?)

**IF PREVIOUS ITEM CODED "3":** During that time, did you lose interest or pleasure in things you usually enjoyed? (What was that like?)

**IF PREVIOUS ITEM NOT CODED "3":** Have you ever had a period when you lost interest or pleasure in things you usually enjoyed? (What was that like?)

**IF YES:** When was that? Was it nearly every day? How long did it last? (As long as 2 weeks?)

Have you had more than one time like that? (Which time was the worst?)

**IF UNCLEAR:** Have you had any times like that in the past year, since (1 year ago)?

### MAJOR DEPRESSIVE EPISODE CRITERIA

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 was either (1) depressed mood or (2) loss of interest or pleasure.

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

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).

**NOTE:** If there is evidence for more than one past episode, select the "worst" one for your inquiry about past Major Depressive Episode. If there was a likely Major Depressive Episode in the past year, ask about that episode even if it was not the worst.
FOR THE FOLLOWING QUESTIONS, FOCUS ON THE WORST 2 WEEKS OF THE PAST MAJOR DEPRESSIVE EPISODE THAT YOU ARE INQUIRING ABOUT.

During that (2-WEEK PERIOD)...

...how was your appetite? (What about compared to your usual appetite? Did you have to force yourself to eat? Eat [less/more] than usual? Was that nearly every day? Did you lose or gain any weight? How much?)

IF YES: Were you trying to [lose/gain] weight?)

...how were you sleeping? (Trouble falling asleep, waking frequently, trouble staying asleep, waking too early, OR sleeping too much? How many hours of sleep (including naps) had you been getting? How many hours of sleep did you typically get before you got (depressed/OWN WORDS)? Has it been nearly every night?)

...were you so fidgety or restless that you were unable to sit still? What about the opposite—talking more slowly, or moving more slowly than was normal for you, as if you were moving through molasses or mud? (In either instance, was it so bad that other people have noticed it? What did they notice? Was that nearly every day?)

...what was your energy level like? (Tired all the time? Nearly every day?)

...were you feeling worthless?
Did you feel guilty about things you had done or not done?

IF YES: What things? (Was this only because you couldn’t take care of things since you have been sick?)

IF YES TO EITHER OF ABOVE: Nearly every day?

...did you have trouble thinking or concentrating? Was it hard to make decisions about everyday things? (What kinds of things did it interfere with?) Nearly every day?

NOTE: When rating the following items, code “1” if clearly directly due to a general medical condition (e.g., insomnia due to severe back pain).

3. Significant weight loss when not dieting, or weight gain (e.g., a change of more than 5% of body weight in a month) or decrease or increase in appetite nearly every day.

Check if:

_____ weight loss or decreased appetite
_____ weight gain or increased appetite

4. Insomnia or hypersomnia nearly every day.

Check if:

_____ insomnia
_____ hypersomnia

5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).

Check if:

_____ psychomotor agitation
_____ psychomotor retardation

6. Fatigue or loss of energy nearly every day

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

8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).

?=inadequate information  1=absent or false  2=subthreshold  3=threshold or true
During that (2-WEEK PERIOD)...

...were things so bad that you thought a lot about death or that you would be better off dead? Did you think about taking your own life?

**IF YES:** Did you do something about it? (What did you do? Did you make a specific plan? Did you take any action to prepare for it? Did you actually make a suicide attempt?)

9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

NOTE: Code "1" for self-mutilation without suicidal intent.

Check if:
- thoughts of own death
- suicidal ideation
- specific plan
- suicide attempt

AT LEAST FIVE OF THE ABOVE SXS (A.1–A.9) ARE CODED "3" AND AT LEAST ONE OF THESE IS ITEM A.1 OR A.2.

**IF NOT ALREADY ASKED:** Has there been any other time when you were (depressed/OWN WORDS) and had even more of the symptoms that I just asked you about?

**IF YES:** RETURN TO *PAST MAJOR DEPRESSIVE EPISODE* A.5, AND CHECK WHETHER THERE HAVE BEEN ANY OTHER MAJOR DEPRESSIVE EPISODES THAT WERE MORE SEVERE AND/OR CAUSED MORE SYMPTOMS. IF SO, ASK ABOUT THAT EPISODE.

**IF NO:** GO TO *CURRENT MANIC EPISODE* A.10.

=?=inadequate information 1=absent or false 2=subthreshold 3=threshold or true
IF UNKNOWN: What effect did (DEPRESSIVE SXS) have on your life?

ASK THE FOLLOWING QUESTIONS AS NEEDED TO RATE CRITERION B:

How did (DEPRESSIVE SXS) affect your relationships or your interactions with other people? (Did this cause you any problems in your relationships with your family, romantic partner or friends?)

How did (DEPRESSIVE SXS) affect your work/school? (How about your attendance at work or school? Did [DEPRESSIVE SXS] make it more difficult to do your work/schoolwork? How did [DEPRESSIVE SXS] affect the quality of your work/schoolwork?)

How did (DEPRESSIVE SXS) affect your ability to take care of things at home? (How about doing simple everyday things like getting dressed, bathing, or brushing your teeth? How about doing other things that are important to you like religious activities, physical exercise, or hobbies? Did you avoid doing anything because you felt like you weren’t up to it?)

Did (DEPRESSIVE SXS) affect any other important part of your life?

IF DID NOT INTERFERE WITH LIFE: How much were you bothered or upset by having (DEPRESSIVE SXS)?

IF NOT ALREADY ASKED: Has there been any other time when you were (depressed/OWN WORDS) and it caused even more problems than the time I just asked you about?

IF YES: RETURN TO *PAST MAJOR DEPRESSIVE EPISODE* A.5, AND CHECK WHETHER THERE HAVE BEEN ANY OTHER MAJOR DEPRESSIVE EPISODES THAT WERE MORE SEVERE AND/OR CAUSED MORE SYMPTOMS. IF SO, ASK ABOUT THAT EPISODE.

IF NO: GO TO *CURRENT MANIC EPISODE* A.10.
IF UNKNOWN: When did this period of (depression/OWN WORDS) begin?

Just before this began, were you physically ill?

IF YES: What did the doctor say?

Just before this began, were you using any medications?

IF YES: Any change in the amount you were using?

Just before this began, were you drinking or using any drugs?

NOTE: Refer to lists of etiological medical conditions and substances/medications on page A.4.

IF UNKNOWN: Has there been any other time when you were having (DEPRESSIVE SXS) like this but were not (using SUBSTANCE/MEDICATION/ill with GMC)?

IF YES: GO TO *PAST MAJOR DEPRESSIVE EPISODE* A.5 AND CHECK WHETHER THERE HAS BEEN ANY OTHER MAJOR DEPRESSIVE EPISODE NOT DUE TO A SUBSTANCE/MEDICATION OR ANOTHER MEDICAL CONDITION. IF SO, ASK ABOUT THAT EPISODE.

IF NO: GO TO *CURRENT MANIC EPISODE* A.10

MAJOR DEPRESSIVE EPISODE CRITERIA A, B, AND C ARE CODED “3.”

How old were you when (PAST MAJOR DEPRESSIVE EPISODE) started?

Age-at-onset of Past Major Depressive Episode coded above.

How many separate times in your life have you been (depressed/OWN WORDS) nearly every day for at least 2 weeks and had several of the symptoms that you described like (SXS OF WORST EPISODE)?

Total number of Major Depressive Episodes (CODE 99 IF TOO NUMEROUS OR INDISTINCT TO COUNT).

? = inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true
**CURRENT MANIC EPISODE**

Since (1 MONTH AGO), has there been a period of time when you were feeling so good, “high,” excited, or “on top of the world” that other people thought you were not your normal self?

**IF YES:** What has it been like? (More than just feeling good?)
- Have you also been feeling like you were “hyper” or “wired” and had an unusual amount of energy? Have you been much more active than is typical for you? (Have other people commented on how much you have been doing?)

**IF NO:** Since (1 MONTH AGO), 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? What has it been like? (Is that different from the way you usually are?)
- If yes: Have you also been feeling like you were “hyper” and had an unusual amount of energy? Have you been much more active than is typical for you? (Have other people commented on how much you have been doing?)

How long has this lasted? (As long as 1 week?)

**IF LESS THAN 1 WEEK:** Did you need to go into the hospital to protect you from hurting yourself or someone else, or from doing something that could have caused serious financial or legal problems?

**MANIC EPISODE CRITERIA**

A. A distinct period [lasting at least several days] of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased [...] activity or energy.

Check if:
- ___ elevated, expansive mood
- ___ irritable mood

...lasting at least 1 week and present most of the day, nearly every day (or any duration if hospitalization is necessary).

**NOTE:** If elevated mood lasts less than 1 week, check whether irritable mood lasts at least 1 week before skipping to A.14.

**GO TO ** PAST MANIC EPISODE** A.18

**GO TO ** CURRENT HYPOMANIC EPISODE** A.14

B. During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree and represent a noticeable change from usual behavior:

1. Inflated self-esteem or grandiosity.
2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep).

Have you been feeling (high/irritable/OWN WORDS) for most of the day, nearly every day during this time?

**FOCUS ON THE MOST SEVERE WEEK IN THE PAST MONTH OF THE CURRENT EPISODE FOR THE FOLLOWING QUESTIONS.**

**IF UNCLAR:** During (EPISODE), when were you the most (high/irritable/OWN WORDS)?

During that time...

...how did you feel about yourself?

1. Inflated self-esteem or grandiosity.
2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep).

...did you need less sleep than usual? (How much sleep did you get?)

**IF YES:** Did you still feel rested?
During that time...

...were you much more talkative than usual? (Did people have trouble stopping you or understanding you? Did people have trouble getting a word in edgewise?)

3. More talkative than usual or pressure to keep talking. ? 1 2 3 A60

...did you have thoughts racing through your head? (What was that like?)

4. Flight of ideas or subjective experience that thoughts are racing. ? 1 2 3 A61

...were you so easily distracted by things around you that you had trouble concentrating or staying on one track? (Give me an example of that.)

5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli) as reported or observed. ? 1 2 3 A62

...how did you spend your time? (Work, friends, hobbies? Were you especially busy during that time?)

6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (i.e., purposeless non-goal-directed activity). ? 1 2 3 A63

(Did you find yourself more enthusiastic at work or working harder at your job? What about being more engaged in school activities or studying harder?)

(Were you more sociable during that time, such as calling on friends or going out with them more than you usually do or making a lot of new friends?)

(Were you spending more time thinking about sex or involved in doing something sexual, by yourself or with others? Was that a big change for you?)

Were you physically restless during this time, doing things like pacing a lot, or being unable to sit still? (How bad was it?)

...were you doing anything that could have caused trouble for you or your family?

7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments). ? 1 2 3 A66

(Spending money on things you didn’t need or couldn’t afford? How about giving away money or valuable things? Gambling with money you couldn’t afford to lose?)

(Anything sexual that was likely to get you in trouble? Driving recklessly?)

(Did you make any risky or impulsive business investments or get involved in a business scheme that you wouldn’t normally have done?)

? = inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true
SCID-RV (for DSM-5®) (Version 1.0.0)  
Current Manic Mood Episodes w/o Specifiers  

A.12

AT LEAST THREE "B" SXS ARE CODED "3" (FOUR IF MOOD ONLY IRRITABLE).

IF UNKNOWN: What effect have these (MANIC SXS) had on your life?

IF UNKNOWN: Have you needed to go into the hospital to protect you from hurting yourself or someone else, or from doing something that could have caused serious financial or legal problems?

ASK THE FOLLOWING QUESTIONS AS NEEDED TO RATE CRITERION C.

How have (MANIC SXS) affected your relationships or your interactions with other people? (Have (MANIC SXS) caused you any problems in your relationships with your family, romantic partner or friends?)

How have (MANIC SXS) affected your work/school? (How about your attendance at work or school? Did [MANIC SXS] make it more difficult to do your work/schoolwork? How have [MANIC SXS] affected the quality of your work/schoolwork?)

How have (MANIC SXS) affected your ability to take care of things at home?

C. The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

NOTE: Code "3" if psychotic symptoms have been present. You may need to return here to recode after screening for psychotic symptoms in Module B.

DESCRIBE:

?=inadequate information  1=absent or false  2=subthreshold  3=threshold or true
SCID-RV (for DSM-5®) (Version 1.0.0)  Current Manic Mood Episodes w/o Specifiers  A.13

**IF UNKNOWN:**  When did this period of being (high/irritable/OWN WORDS) begin?

Just before this began, were you physically ill?

**IF YES:**  What did the doctor say?

Just before this began, were you taking any medications?

**IF YES:**  Any change in the amount you were taking?

Just before this began, were you drinking or using any drugs?

D. [Primary Manic Episode:] The episode is not attributable to the physiological effects of a substance (i.e., a drug of abuse, medication) or to another medical condition.

IF THERE IS ANY INDICATION THAT MANIA MAY BE SECONDARY (I.E., A DIRECT PHYSIOLOGICAL CONSEQUENCE OF A GMC OR SUBSTANCE), GO TO *GMC/SUBSTANCE* A.41 AND RETURN HERE TO MAKE A RATING OF “1” OR “3.”

**NOTE:** A full Manic Episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a Manic Episode and, therefore, a Bipolar I diagnosis.

Etiological medical conditions include: Alzheimer’s disease, vascular dementia, HIV-induced dementia, Huntington’s disease, Lewy body disease, Wernicke-Korsakoff, Cushing’s disease, multiple sclerosis, ALS, Parkinson’s disease, Pick’s disease, Creutzfeld-Jakob disease, stroke, traumatic brain injuries, hyperthyroidism

Etiological substances/medications include: alcohol (I/W), phencyclidine (I), hallucinogens (I), sedatives, hypnotics, anxiolytics (I/W), amphetamines (I/W), cocaine (I/W), corticosteroids, androgens, isoniazid, levodopa, interferon alpha, varenicline, procarbazine, clarithromycin, ciprofloxacin

MANIC EPISODE CRITERIA A, B, C, AND D ARE CODED “3.”

? = inadequate information  1 = absent or false  2 = subthreshold  3 = threshold or true
**CURRENT HYPOMANIC EPISODE**

**HYPOMANIC EPISODE CRITERIA**

*IF CRITERIA ARE MET FOR A CURRENT MANIC EPISODE, CHECK HERE_____ AND GO TO *PREMENSTRUAL DYSPHORIC DISORDER* A.36.*

Has the period when you were feeling (high/irritable/OWN WORDS), lasted for at least 4 days? Has it lasted for most of the day, nearly every day?

A. A distinct period of abnormally and persistently elevated, expansive or irritable mood and abnormally and persistently increased activity or energy, lasting at least 4 consecutive days, and present most of the day, nearly every day.

Check if:

___ elevated, expansive mood
___ irritable mood

Have you had more than one time like that since (1 MONTH AGO)? (Which one was the most extreme?)

**FOCUS ON THE MOST EXTREME PERIOD IN THE PAST MONTH OF THE CURRENT EPISODE FOR THE FOLLOWING QUESTIONS.**

(During that time...)

...how were you feeling about yourself? (More self-confident than usual?) (Did you feel much smarter or better than everyone else?) (Did you feel like you had any special powers or abilities?)

1. Inflated self-esteem or grandiosity.

...did you need less sleep than usual? (How much sleep were you getting?)

   IF YES: Were you still feeling rested?

2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep).

...were you much more talkative than usual? (Did people have trouble stopping you, understanding you, or getting a word in edgewise?)

3. More talkative than usual or pressure to keep talking.

...did you have thoughts racing through your head? (What was that like?)

4. Flight of ideas or subjective experience that thoughts are racing.

...were you so easily distracted by things around you that you had trouble concentrating or staying on one track? (Give me an example of that.)

5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.

? = inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true
During that time...

...how were you spending your time? (Work, friends, hobbies? Were you been especially productive or busy?)

(Were you finding yourself more enthusiastic at work or working harder at your job? What about being more engaged in school activities or studying harder?)

(Were you more sociable, such as calling on friends or going out with them more than you usually do or making a lot of new friends?)

(Were you spending more time thinking about sex or doing something sexual, by yourself or with others? Was this a big change for you?)

Were you physically restless during this time, doing things like pacing a lot, or being unable to sit still? (How bad was it?)

...were you doing anything that could have caused trouble for you or your family?

(Spending money on things you didn’t need or couldn’t afford? How about giving away money or valuable things? Gambling with money you couldn’t afford to lose?)

(Anything sexual that was likely to get you in trouble? Driving recklessly?)

(Did you make any risky or impulsive business investments or get involved in a business scheme that you wouldn’t normally have done?)

6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation.

   Check if:
   ___ increase in activity
   ___ psychomotor agitation

7. Excessive involvement in activities which have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

AT LEAST THREE "B" SXS ARE CODED "3" (FOUR IF MOOD ONLY IRRITABLE).

NOTE: Because of the inherent difficulty in distinguishing normal periods of good mood from hypomania, review all items coded "3" in criterion B and recode any equivocal judgments.
*CURRENT HYPOMANIC CRITERION C*

**IF UNKNOWN:** Was this very different from the way you usually are when you’re not (high/irritable/OWN WORDS)? (How were you different? At work? With friends?)

C. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the individual when not symptomatic.

**IF UNKNOWN:** Did other people notice the change in you? (What did they say?)

D. The disturbance in mood and the change in functioning are observable by others.

**IF UNKNOWN:** What effect have these (HYPOMANIC SXS) had on your life?

ASK THE FOLLOWING QUESTIONS AS NEEDED TO RATE CRITERION E.

How have (HYPOMANIC SXS) affected your relationships or your interactions with other people? (Has this caused any problems in your relationships with your family, romantic partner or friends?)

How have (HYPOMANIC SXS) affected your school/work? (How about your attendance at work or school? Did [HYPOMANIC SXS] make it more difficult to do your work/schoolwork? How have [HYPOMANIC SXS] affected the quality of your work/schoolwork?)

How has this affected your ability to take care of things at home?

**IF UNKNOWN:** Have you needed to go into the hospital to protect you from hurting yourself or someone else, or from doing something that could have caused serious financial or legal problems?

**IF SEVERE ENOUGH TO REQUIRE HOSPITALIZATION OR SEVERE ENOUGH TO CAUSE MARKED IMPAIRMENT AND DURATION WAS AT LEAST 1 WEEK, CHECK HERE ____ AND GO TO A.10 AND TRANSCRIBE B CRITERION SYMPTOM RATINGS AND CONTINUE WITH RATINGS FOR CURRENT MANIC EPISODE.**

**IF SEVERE ENOUGH TO CAUSE MARKED IMPAIRMENT BUT LASTED LESS THAN 1 WEEK, CHECK HERE ____ AND GO TO *PAST MANIC EPISODE* A.18. IF CRITERIA ARE NOT MET FOR A PAST MANIC EPISODE, CODE “OTHER BIPOLAR DISORDER” FOR THIS SEVERE BUT BRIEF EPISODE, AND INDICATE TYPE 5 ON D.8.**

?=inadequate information 1=absent or false 2=subthreshold 3=threshold or true
IF UNKNOWN: When did this period of being (high/irritable/OWN WORDS) begin?

Just before this began, were you physically ill?
   IF YES: What did the doctor say?

Just before this began, were you taking any medications?
   IF YES: Any change in the amount you were taking?

Just before this began, were you drinking or using any drugs?

F. [Primary Hypomanic Episode:] The episode is not attributable to the physiological effects of a substance/medication or to another medical condition.

IF THERE IS ANY INDICATION THAT THE HYPOMANIA MAY BE SECONDARY (I.E., A DIRECT PHYSIOLOGICAL CONSEQUENCE OF GMC OR SUBSTANCE), GO TO *GMC/SUBSTANCE* A.41, AND RETURN HERE TO MAKE A RATING OF "1" OR "3."

NOTE: A full Hypomanic Episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a Hypomanic Episode diagnosis. However, caution is indicated so that one or two symptoms (particularly increased irritability, edginess, or agitation following antidepressant use) are neither taken as sufficient for diagnosis of a hypomanic episode, nor necessarily indicative of a bipolar diathesis.

NOTE: Refer to lists of etiological medical conditions and substances/medications on page A.13.

HYPOMANIC EPISODE CRITERIA A, B, C, D, E, AND F ARE CODED "3."

?=inadequate information   1=absent or false   2=subthreshold   3=threshold or true
**PAST MANIC EPISODE**

NOTE: IF CURRENTLY ELEVATED OR IRRITABLE MOOD BUT FULL CRITERIA ARE NOT MET FOR A MANIC EPISODE, SUBSTITUTE THE PHRASE “Has there ever been another time . . .” IN EACH OF THE SCREENING QUESTIONS BELOW.

Have you ever had a period of time when you were feeling so good, “high,” excited, or “on top of the world” that other people thought you were not your normal self?

**IF YES:** What was it like? (Was that more than just feeling good?) Did you also feel like you were “hyper” or “wired” and had an unusual amount of energy? Were you much more active than is typical for you? (Did other people comment on how much you were doing?)

**IF NO:** Have you ever had a period of time when you were feeling irritable, angry, or short-tempered for most of the day, every day, for at least several days? What was that like? (Was that different from the way you usually are?)

**IF YES:** Did you also feel like you were “hyper” or “wired” and had an unusual amount of energy? Were you much more active than is typical for you? (Did other people comment on how much you were doing?)

When was that?

How long did that last? (As long as 1 week?)

**IF LESS THAN 1 WEEK:** Did you need to go into the hospital to protect you from hurting yourself or someone else, or from doing something that could have caused serious financial or legal problems?

Did you feel (high/irritable/OWN WORDS) for most of the day, nearly every day during this time?

Have you had more than one time like that? (Which time was the most extreme?)

**IF UNCLEAR:** Have you had any times like that in the past year, since (1 YEAR AGO)?

---

**MANIC EPISODE CRITERIA**

A. A distinct period [lasting at least several days] of abnormally and persistently elevated, expansive or irritable mood and abnormally and persistently increased [...] activity or energy.

Check if:

___ elevated, expansive mood

___ irritable mood

When was that?

How long did that last? (As long as 1 week?)

**IF LESS THAN 1 WEEK:** Did you need to go into the hospital to protect you from hurting yourself or someone else, or from doing something that could have caused serious financial or legal problems?

Did you feel (high/irritable/OWN WORDS) for most of the day, nearly every day during this time?

Have you had more than one time like that? (Which time was the most extreme?)

**IF UNCLEAR:** Have you had any times like that in the past year, since (1 YEAR AGO)?

---

? = inadequate information  
1 = absent or false  
2 = subthreshold  
3 = threshold or true
FOCUS ON THE WORST PERIOD OF THE EPISODE THAT YOU ARE INQUIRING ABOUT.

IF UNCLEAR: During (EPISODE), when were you the most (high/irritable/OWN WORDS)?

During that time...

...how did you feel about yourself? (More self-confident than usual? Did you feel much smarter or better than everyone else? Did you feel like you had any special powers or abilities?)

...did you need less sleep than usual? (How much sleep did you get?)

IF YES: Did you still feel rested?

...were you much more talkative than usual? (Did people have trouble stopping you or understanding you? Did people have trouble getting a word in edgewise?)

...did you have thoughts racing through your head? (What was that like?)

...were you so easily distracted by things around you that you had trouble concentrating or staying on one track? (Give me an example of that.)

...how did you spend your time? (Work, friends, hobbies? Were you especially busy during that time?)

(Did you find yourself more enthusiastic at work or working harder at your job? Did you find yourself more engaged in school activities or studying harder?)

(Were you more sociable during that time, such as calling on friends or going out with them more than you usually do or making a lot of new friends?)

(Were you spending more time thinking about sex or involved in doing something sexual, by yourself or with others? Was that a big change for you?)

Were you physically restless during this time, doing things like pacing a lot, or being unable to sit still? (How bad was it?)

\[\text{A.19}
\]

B. During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree and represent a noticeable change from usual behavior:

1. Inflated self-esteem or grandiosity. ? 1 2 3 A96

2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep). ? 1 2 3 A97

3. More talkative than usual or pressure to keep talking. ? 1 2 3 A98

4. Flight of ideas or subjective experience that thoughts are racing. ? 1 2 3 A99

5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli) as reported or observed. ? 1 2 3 A100

6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (i.e., purposeless non-goal-directed activity).

\[
\text{Check if:} \\
\text{___ increase in activity} \\
\text{___ psychomotor agitation} \\
\text{A102 A103}\]
During that time…

...did you do anything that could have caused trouble for you or your family?

(Spending money on things you didn’t need or couldn’t afford? How about giving away money or valuable things? Gambling with money you couldn’t afford to lose?)

(Anything sexual that was likely to get you in trouble? Driving recklessly?)

(Did you make any risky or impulsive business investments or get involved in a business scheme that you wouldn’t normally have done?)

7. Excessive involvement in activities which have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

IF NOT ALREADY ASKED: Has there been any other time when you were (high/irritable/OWN WORDS) and had even more of the symptoms that I just asked you about?

IF YES: RETURN TO *PAST MANIC EPISODE* A.18, AND INQUIRE ABOUT WORST EPISODE.

IF NO: GO TO *CURRENT CYCLOTHYMIC DISORDER* A.28.

AT LEAST THREE "B" SXS ARE CODED "3" (FOUR IF MOOD ONLY IRRITABLE).
IF UNKNOWN: What effect did these (MANIC SXS) have on your life?

IF UNKNOWN: Did you need to go into the hospital to protect you from hurting yourself or someone else, or from doing something that could have caused serious financial or legal problems?

ASK THE FOLLOWING QUESTIONS AS NEEDED TO RATE CRITERION C.

How did (MANIC SXS) affect your relationships or your interactions with other people? (Did (MANIC SXS) cause you any problems in your relationships with your family, romantic partner or friends?)

How did (MANIC SXS) affect your work/school? (How about your attendance at work or school? Did [MANIC SXS] make it more difficult to do your work/schoolwork? How did [MANIC SXS] affect the quality of your work/schoolwork?)

How did (MANIC SXS) affect your ability to take care of things at home?

IF NOT ALREADY ASKED: Has there been any other time when you were (high/irritable/OWN WORDS) and had (ACKNOWLEDGED MANIC SYMPTOMS) and you got into trouble with people or were hospitalized?

IF YES: RETURN TO *PAST MANIC EPISODE* A.18, AND INQUIRE ABOUT OTHER EPISODE.

IF NO: GO TO *PAST HYPOMANIC CRITERION C* A.25

? = inadequate information  1 = absent or false  2 = subthreshold  3 = threshold or true
**IF UNKNOWN: When did this period of being (high/irritable/OWN WORDS) begin?**

Just before this began, were you physically ill?

*IF YES:* What did the doctor say?

Just before this began, were you taking any medications?

*IF YES:* Any change in the amount you were taking?

Just before this began, were you drinking or using any drugs?

D. [Primary Manic Episode:] The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, medication) or to another medical condition.

**IF THERE IS ANY INDICATION THAT THE MANIA MAY BE SECONDARY (I.E., A DIRECT PHYSIOLOGICAL CONSEQUENCE OF GMC OR SUBSTANCE), GO TO *GMC/SUBSTANCE* A.41, AND RETURN HERE TO MAKE A RATING OF "1" OR "3."**

NOTE: A full Manic Episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a Manic Episode and, therefore, a Bipolar I diagnosis.

NOTE: Refer to lists of etiological medical conditions and substances/medications on page A.13.

**IF UNKNOWN:** Has there been any other time when you were (high/irritable/OWN WORDS) and were not (using SUBSTANCE/ill with AMC)?

*IF YES:* RETURN TO *PAST MANIC EPISODE* A.18, AND INQUIRE ABOUT OTHER EPISODE.

*IF NO:* GO TO *CURRENT CYCLOTHYMIC DISORDER* A.28.

**MANIC EPISODE CRITERIA A, B, C, AND D ARE CODED "3."**

**How old were you when (PAST MANIC EPISODE) started?**

Age-at-onset of Past Manic Episode coded above

---

?=inadequate information  1=absent or false  2=subthreshold  3=threshold or true
**PAST HYPOMANIC EPISODE**

When you were (high/irritable/OWN WORDS), did it last for at least 4 days? (Did it last for most of the day, nearly every day?)

What was it like?

Have you had more than one time like that? (Which time was the most extreme?)

**IF UNCLEAR:** Have you had any times like that in the past year, since (1 YEAR AGO)?

**FOCUS ON THE WORST PERIOD OF THE EPISODE THAT YOU ARE INQUIRING ABOUT.**

**IF UNCLEAR:** During (EPISODE), when were you the most (high/irritable/OWN WORDS FOR HYPOMANIA)?

During that time...

...how did you feel about yourself?

(More self-confident than usual? Did you feel much smarter or better than everyone else? Did you feel like you had any special powers or abilities?)

...did you need less sleep than usual? (How much sleep did you get?)

**IF YES:** Did you still feel rested?

...were you much more talkative than usual? (Did people have trouble stopping you or understanding you? Did people have trouble getting a word in edgewise?)

...did you have thoughts racing through your head? (What was that like?)

...were you so easily distracted by things around you that you had trouble concentrating or staying on one track? (Give me an example of that.)

**HYPOMANIC EPISODE CRITERIA**

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least 4 consecutive days and persistent most of the day, nearly every day.

Check if:

___ elevated, expansive mood
___ irritable mood

NOTE: If there is evidence for more than one past episode, select the "worst" one for your inquiry about past Hypomanic Episode. If there was an episode in the past year, ask about that episode even if it was not the worst.

B. During the period of mood disturbance and increased energy and activity, 3 (or more) of the following symptoms (4 if the mood is only irritable) have persisted, represent a noticeable change from usual behavior, and have been present to a significant degree and represent a noticeable change from usual behavior:

1. Inflated self-esteem or grandiosity.

2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep).

3. More talkative than usual or pressure to keep talking.

4. Flight of ideas or subjective experience that thoughts are racing.

5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.

? inadequate information 1 absent or false 2 subthreshold 3 threshold or true
During that time...

...how did you spend your time? (Work, friends, hobbies? Were you especially productive or busy during that time?)

(Did you find yourself more enthusiastic at work or working harder at your job? Did you find yourself more engaged in school activities or studying harder?)

(Were you more sociable during that time, such as calling on friends or going out with them more than you usually do or making a lot of new friends?)

(Were you spending more time thinking about sex or involved in doing something sexual, by yourself or with others? Was that a big change for you?)

Were you physically restless during this time, doing things like pacing a lot, or being unable to sit still? (How bad was it?)

...did you do anything that could have caused trouble for you or your family?

(Spending money on things you didn’t need or couldn’t afford? How about giving away money or valuable things? Gambling with money you couldn’t afford to lose?)

(Anything sexual that was likely to get you in trouble? Driving recklessly?)

(Did you make any risky or impulsive business investments or get involved in a business scheme that you wouldn’t normally have done?)

6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation.

Check if:

_____ increase in activity
_____ psychomotor agitation

7. Excessive involvement in activities which have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

? 1 2 3

?=inadequate information 1=absent or false 2=subthreshold 3=threshold or true
SCID-RV (for DSM-5®) (Version 1.0.0)  
Past Hypomanic Episode  
Mood Episodes w/o Specifiers  A.25

AT LEAST 3 "B" SXS ARE CODED "3" (4 IF MOOD ONLY IRRITABLE).

NOTE: Because of the inherent difficulty in distinguishing normal periods of good mood from hypomania, review all items coded "3" in criterion B and recode any equivocal judgments.

CONTINUE WITH NEXT ITEM

IF NOT ALREADY ASKED: Has there been any other time when you were (high/irritable/OWN WORDS) and had even more of the symptoms that I just asked you about?

IF YES: RETURN TO *PAST HYPOMANIC EPISODE* A.23 AND INQUIRE ABOUT THAT EPISODE.

IF NO: GO TO *CURRENT CYCLOTHYMIC DISORDER* A.28.

*PAST HYPOMANIC CRITERION C*

IF NOT KNOWN: Was that very different from the way you usually are? (How were you different? At work? With friends?)

C. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the individual when not symptomatic.

DESCRIBE:

CONTINUE ON NEXT PAGE

IF NOT ALREADY ASKED: Have there been any other times when you were (high/irritable/OWN WORDS) in which you were really different from the way you usually are?

IF YES: RETURN TO *PAST HYPOMANIC EPISODE* A.23 AND INQUIRE ABOUT THAT EPISODE.

IF NO: GO TO *CURRENT CYCLOTHYMIC DISORDER* A.28.

?=inadequate information  1=absent or false  2=subthreshold  3=threshold or true
IF NOT KNOWN: Did other people notice the change in you? (What did they say?)

D. The disturbance in mood and the change in functioning are observable by others.

IF NOT ALREADY ASKED: Have there been any other times when you were (high/irritable/OWN WORDS) and other people did notice the change in the way you were acting?

IF YES: RETURN TO *PAST HYPOMANIC EPISODE* A.23 AND INQUIRE ABOUT THAT EPISODE.

IF NO: GO TO *CURRENT CYCLOTHYMIC DISORDER* A.28.

IF UNKNOWN: What effect did these (HYPOMANIC SXS) have on your life?

ASK THE FOLLOWING QUESTIONS AS NEEDED TO RATE CRITERION:

How did (HYPOMANIC SXS) affect your relationships or your interactions with other people? (Did they cause you any problems in your relationships with your family, romantic partner or friends?)

How did (HYPOMANIC SXS) affect your work/school? (How about your attendance at work or school? Did [HYPOMANIC SXS] affect the quality of your work/schoolwork?)

How did (HYPOMANIC SXS) affect your ability to take care of things at home?

IF UNKNOWN: Did you need to go into the hospital to protect you from hurting yourself or someone else, or from doing something that could have caused serious financial or legal problems?

IF SEVERE ENOUGH TO REQUIRE HOSPITALIZATION OR SEVERE ENOUGH TO CAUSE MARKED IMPAIRMENT AND DURATION WAS AT LEAST 1 WEEK, CHECK HERE ___ AND GO TO A.19 AND TRANSCRIBE B CRITERION SYMPTOM RATINGS AND CONTINUE WITH RATINGS FOR PAST MANIC EPISODE.

IF SEVERE ENOUGH TO CAUSE MARKED IMPAIRMENT BUT LASTED LESS THAN 1 WEEK, CHECK HERE ___ AND GO TO *CURRENT CYCLOTHYMIC DISORDER* A.28. IF CRITERIA ARE NOT MET FOR A PAST MANIC EPISODE, CODE "OTHER BIPOLAR DISORDER" FOR THIS SEVERE BUT BRIEF EPISODE, AND INDICATE "TYPE 5" ON D.8.

?=inadequate information 1=absent or false 2=subthreshold 3=threshold or true
**SCID-RV (for DSM-5®) (Version 1.0.0)**

**Past Hypomanic Episode**

**Mood Episodes w/o Specifiers** A.27

**IF UNKNOWN:** When did this period of being (high/irritable/OWN WORDS) begin?

Just before this began, were you physically ill?

**IF YES:** What did the doctor say?

Just before this began, were you taking any medications?

**IF YES:** Any change in the amount you were taking?

Just before this began, were you drinking or using any drugs?

**F.** [Primary Hypomanic Episode:] The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, medication) or to another medical condition.

**IF THERE IS ANY INDICATION THAT THE HYPOMANIA MAY BE SECONDARY (I.E., A DIRECT PHYSIOLOGICAL CONSEQUENCE OF GMC OR SUBSTANCE* A.41, AND RETURN HERE TO MAKE A RATING OF “1” OR “3.”

NOTE: A full hypomanic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a hypomanic episode diagnosis. However, caution is indicated so that one or two symptoms (particularly increased irritability, edginess, or agitation following antidepressant use) are neither taken as sufficient for diagnosis of a hypomanic episode, nor necessarily indicative of a bipolar diathesis.

NOTE: Refer to lists of etiological medical conditions and substances/medications on page A.13.

**How old were you when (PAST HYPOMANIC EPISODE) started?**

Age at onset of Past Hypomanic Episode coded above.

**GO TO**

*PREMENSTRUAL DYSPHORIC DISORDER* A.36

? = inadequate information
1 = absent or false
2 = subthreshold
3 = threshold or true
SCID-RV (for DSM-5®) (Version 1.0.0)  Current Cyclothymic Disorder  Mood Episodes w/o Specifiers  A.28

**CURRENT CYCLOTHYMIC DISORDER**

**CURRENT CYCLOTHYMIC DISORDER CRITERIA**

*IF THERE HAS EVER BEEN A MAJOR DEPRESSIVE, MANIC, OR HYPOMANIC EPISODE, CHECK HERE ___ AND GO TO *CURRENT PERSISTENT DEPRESSIVE DISORDER* A.30.*

For the past couple of years, since (2 YEARS AGO), 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?

*IF YES:  Tell me about that.*

 Were you like this for most of the time since (2 YEARS AGO)?

*IF YES:  Since (2 YEARS AGO), what is the longest period of time in which you felt OK, that is, neither high, irritable, down, nor depressed?*

*IF NOT ALREADY CLEAR: RETURN TO THIS ITEM AFTER COMPLETING THE PSYCHOTIC DISORDERS SECTION.*

*IF UNKNOWN:  When did this begin?*

Just before this began, were you physically ill?

*IF YES:  What did the doctor say?*

Just before this began, were you using any medications?

*IF YES:  Any change in the amount you were using?*

Just before this began, were you drinking or using any drugs?

*IF THERE IS ANY INDICATION THAT THE HYPOMANIC AND DEPRESSIVE SXS MAY BE SECONDARY (I.E., A DIRECT PHYSIOLOGICAL CONSEQUENCE OF GMC OR SUBSTANCE), GO TO *GMC/SUBSTANCE/MEDICATION* A.41, AND RETURN HERE TO MAKE A RATING OF "1" OR "3."

NOTE: Refer to lists of etiological medical conditions and substances/medications on page A.13.

? = inadequate information   1 = absent or false   2 = subthreshold   3 = threshold or true
IF UNKNOWN: **What effect have the mood swings had on your life? (For example, when you are feeling good, do you take things on but then not follow through when you get depressed?)**

**ASK THE FOLLOWING QUESTIONS AS NEEDED TO RATE CRITERION F:**

How have mood swings affected your relationships or your interactions with other people? (Have they caused you any problems in your relationships with your family, romantic partner or friends?)

How have the mood swings affected your work/school? (How about your attendance at work or school? Did they make it more difficult to do your work/schoolwork? How have the mood swings affected the quality of your work/schoolwork?)

How have the mood swings affected your ability to take care of things at home?

Have the mood swings affected any other important part of your life?

**IF HAVE NOT INTERFERED WITH LIFE:** How much have you been bothered or upset by having mood swings?

F. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

SCID-RV (for DSM-5®) (Version 1.0.0)  Current Cyclothymic Disorder  Mood Episodes w/o Specifiers  A.29

Because of the presence of mood swings, the mood disorders must be coded separately, both for the cyclothymic disorder and for the mood episodes. The symptom criteria (A, B, C, D, E, F) are rated separately for each of these disorders. Cyclothymic Disorder Criteria A, B, C, D, E, and F are coded ‘3.’

? = inadequate information  1 = absent or false  2 = subthreshold  3 = threshold or true

Go to *Current Persistent Depressive Disorder* A.30

Go to *Current Cyclothymic Disorder*
**CURRENT PERSISTENT DEPRESSIVE DISORDER***

**CURRENT PERSISTENT DEPRESSIVE DISORDER CRITERIA**

*IF THERE HAS EVER BEEN A MANIC OR HYPOMANIC EPISODE, CHECK HERE ___ AND GO TO *PREMENSTRUAL DYSPHORIC DISORDER* A.36.*

Since (2 YEARS AGO), have you been bothered by depressed mood most of the day, more days than not? (More than half of the time?)

*IF YES:* What has that been like?

During these periods (OWN WORDS FOR CHRONIC DEPRESSION) did you often...

...lose your appetite? (What about overeating?)

...have trouble sleeping or sleep too much?

...have little energy to do things or feel tired a lot?

...feel down on yourself? (Feel worthless, or a failure?)

...have trouble concentrating or making decisions?

...feel hopeless?

A. Depressed mood for most of the day, for more days than not, as indicated either by subjective account or observation by others, for at least 2 years. NOTE: in adolescents, mood can be irritable and duration must be at least 1 year.  

B. Presence, while depressed, of two (or more) of the following:

1. Poor appetite or overeating.  

2. Insomnia or hypersomnia.  

3. Low energy or fatigue.  

4. Low self-esteem.  

5. Poor concentration or difficulty making decisions.  

6. Feelings of hopelessness.  

AT LEAST TWO "B" SYMPTOMS ARE CODED "3."

C. During the 2-year period (1 year for children or adolescents) of the disturbance, the individual has never been without the symptoms in Criteria A and B for more than 2 months at a time.

**Since (2 YEARS AGO), what was the longest period of time that you felt OK (NO DYSTHYMIC SYMPTOMS)?**

NOTE: Code "1" if normal mood for more than 2 months at a time.

E. There has never been a Manic Episode or a Hypomanic Episode, and criteria have never been met for Cyclothymic disorder.

? = inadequate information  
1 = absent or false  
2 = subthreshold  
3 = threshold or true
IF NOT ALREADY CLEAR, RETURN TO THIS ITEM AFTER COMPLETING THE PSYCHOTIC DISORDERS SECTION.

NOTE: Code “3” if NO chronic psychotic disorder has been present or if NOT better explained by a chronic psychotic disorder.

IF UNKNOWN: When did this begin?

Just before this began, were you physically ill?

IF YES: What did the doctor say?

Just before this began, were you using any medications?

IF YES: Any change in the amount you were using?

Just before this began, were you drinking or using any drugs?

IF UNKNOWN: What effect have these (DEPRESSIVE SXS) had on your life?

ASK THE FOLLOWING QUESTIONS AS NEEDED TO RATE CRITERION H:

How have (DEPRESSIVE SXS) affected your relationships or your interactions with other people? (Has it caused you any problems in your relationships with your family, romantic partner or friends?)

How have these (DEPRESSIVE SXS) affected your work/school? (How about your attendance at work or school? Have [DEPRESSIVE SXS] made it more difficult to do your work/schoolwork? How did [DEPRESSIVE SXS] affect the quality of your work/schoolwork?)

How have (DEPRESSIVE SXS) affected your ability to take care of things at home? How about doing simple everyday things like getting dressed, bathing, or brushing your teeth? How about doing other things that are important to you like religious activities, physical exercise, or hobbies? Did you avoid doing anything because you felt like you weren’t up to it?

?=inadequate information 1=absent or false 2=subthreshold 3=threshold or true
Have these (DEPRESSIVE SXS) affected any other important part of your life?

IF DOES NOT INTERFERE WITH LIFE: How much you been bothered or upset by having (DEPRESSIVE SXS)?

PERSISTENT DEPRESSIVE DISORDER CRITERIA A, B, C, D, E, F, G, AND H ARE CODED "3."

Specify if (for most recent 2 years of Persistent Depressive Disorder):

With pure dysthymic syndrome: Full criteria for a Major Depressive Episode have not been met in at least the preceding 2 years.

With persistent Major Depressive Episode: Full criteria for a Major Depressive Episode have been met throughout the preceding 2-year period.

With intermittent Major Depressive Episodes, with current episode: Full criteria for a Major Depressive Episode are currently met, but there have been periods of at least 8 weeks in at least the preceding 2 years with symptoms below the threshold for a full Major Depressive Episode.

With intermittent Major Depressive Episodes, without current episode: Full criteria for a Major Depressive Episode are not currently met, but there has been one or more Major Depressive Episodes in at least the preceding 2 years.

Specify if:

IF UNKNOWN: Have there been any panic attacks in the past month?

With panic attacks: if one or more panic attacks in the past month occurred in the context of current Persistent Depressive Disorder (see page F.7) and criteria have never been met for Panic Disorder.
**PAST PERSISTENT DEPRESSIVE DISORDER**

**IF NO CURRENT TWO YEAR PERIOD OF DEPRESSED MOOD:** Have you ever had a period of time, lasting for at least 2 years, when you have been bothered by depressed mood most of the day, more days than not? (More than half of the time?)

*IF YES:* What was that like?

**IF CURRENT TWO YEAR PERIOD OF DEPRESSED MOOD:** Prior to the past two years, have you ever had a period of time, lasting for at least 2 years, when you have been bothered by depressed mood most of the day, more days than not? (More than half of the time?)

*IF YES:* What was that like?

During these periods of (OWN WORDS FOR CHRONIC DEPRESSION) did you often...

1. Poor appetite or overeating.
2. Insomnia or hypersomnia.
3. Low energy or fatigue.
4. Low self-esteem.
5. Poor concentration or difficulty making decisions.
6. Feelings of hopelessness.

AT LEAST TWO "B" SYMPTOMS ARE CODED "3."

1. Poor appetite or overeating.
2. Insomnia or hypersomnia.
3. Low energy or fatigue.
4. Low self-esteem.
5. Poor concentration or difficulty making decisions.
6. Feelings of hopelessness.

*GO TO PREMENSTRUAL DYSPHORIC DISORDER* A.36

?=inadequate information 1=absent or false 2=subthreshold 3=threshold or true
What was the longest period of time during this period of long-lasting depression, that you felt OK (NO DYSTHYMIC SYMPTOMS)?

C. During the 2-year period (1 year for children or adolescents) of the disturbance, the individual has never been without the symptoms in Criteria A and B for more than 2 months at a time.

NOTE: Code "1" if normal mood for more than 2 months at a time.

E. There has never been a Manic Episode or a Hypomanic Episode, and criteria have never been met for Cyclothymic disorder.

F. The disturbance is not better explained by a Persistent Schizoaffective Disorder, Schizophrenia, Delusional Disorder, or Other Specified or Unspecified Schizophrenia Spectrum or Other Psychotic Disorder.

NOTE: Code "3" if NO chronic psychotic disorder has been present or if NOT better explained by a chronic psychotic disorder.

IF UNKNOWN: When did this begin?

Just before this began, were you physically ill?

IF YES: What did the doctor say?

Just before this began, were you using any medications?

IF YES: Any change in the amount you were using?

Just before this began, were you drinking or using any drugs?

IF THERE IS ANY INDICATION THAT THE DEPRESSION MAY BE SECONDARY (I.E., A DIRECT PHYSIOLOGICAL CONSEQUENCE OF GMC OR SUBSTANCE), GO TO *GMC/SUBSTANCE/MEDICATION* A.45 AND RETURN HERE TO MAKE A RATING OF "1" OR "3."

NOTE: Refer to lists of etiological medical conditions and substances/medications on page A.4.

?=inadequate information 1=absent or false 2=subthreshold 3=threshold or true
IF UNKNOWN: What effect did these (DEPRESSIVE SXS) have on your life?

ASK THE FOLLOWING QUESTIONS AS NEEDED TO RATE CRITERION H:

How have (DEPRESSIVE SXS) affected your relationships or your interactions with other people? (Have (DEPRESSIVE SXS) caused you any problems in your relationships with your family, romantic partner or friends?)

How have these (DEPRESSIVE SXS) affected your work/school? (How about your attendance at work or school? Did [DEPRESSIVE SXS] make it more difficult to do your work/schoolwork? How did [DEPRESSIVE SXS] affect the quality of your work/schoolwork?)

How have (DEPRESSIVE SXS) affected your ability to take care of things at home? How about doing simple everyday things like getting dressed, bathing, or brushing your teeth? How about doing other things that are important to you like religious activities, physical exercise, or hobbies? Did you avoid doing anything because you felt like you weren’t up to it?

Have these (DEPRESSIVE SXS) affected any other important part of your life?

IF DID NOT INTERFERE WITH LIFE: How much have you been bothered or upset by having (DEPRESSIVE SXS)?

H. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

? 1 2 3 A169

GO TO *PREMENSTRUAL DYSPHORIC DISORDER* A.36

PERSISTENT DEPRESSIVE DISORDER CRITERIA A, B, C, D, E, F, G, AND H ARE CODED “3.”

GO TO *PREMENSTRUAL DYSPHORIC DISORDER* A.36

PAST PERSISTENT DEPRESSIVE DISORDER

Indicate onset specifier: (circle the appropriate number)
1 - Early onset: onset before age 21
2 - Late onset: onset age 21 or

?=inadequate information 1=absent or false 2=subthreshold 3=threshold or true
PREMENSTRUAL DYSPHORIC DISORDER* (PAST 12 MONTHS)

*PREMENSTRUAL DYSPHORIC DISORDER* (PAST 12 MONTHS)

IF SUBJECT IS A BIOLOGICAL MALE, POST-MENOPAUSAL FEMALE, PREGNANT FEMALE, OR FEMALE WITH HYSTERECTOMY PLUS OOPHORECTOMY, CHECK HERE ____ AND SKIP TO NEXT MODULE.

Looking back over your menstrual cycles for the past 12 months, since (1 YEAR AGO), have 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?

IF YES: After your period began, did the problems disappear for at least a week?

For how many days during a cycle did you have symptoms?

Since (1 YEAR AGO), did this happen for most of your cycles?

Think of the most severe premenstrual time you experienced since (1 YEAR AGO). Tell me about that time.

Now I’m going to ask you some specific questions about that premenstrual time.

...did you have mood swings in which you would feel suddenly sad or tearful?

IF NO: How about getting unusually upset if someone criticized or rejected you?

IF YES TO EITHER: Did this go away when your menstrual period began or shortly after?

...were you especially irritable or angry?

IF NO: How about getting into a lot of fights or arguments with other people?

IF YES TO EITHER: Did this go away when your menstrual period began or shortly after?

A. In the majority of menstrual cycles, at least five symptoms must be present in the final week before the onset of menses, start to improve within a few days after the onset of menses, and become minimal or absent in the week postmenses.

NOTE: If number of days of symptoms is 20 per month or greater, recheck symptom-free and symptom present intervals.

B. One (or more) of the following symptoms must be present:

1. Marked affective liability (e.g., mood swings; feeling suddenly sad or tearful, or increased sensitivity to rejection).

2. Marked irritability or anger or increased interpersonal conflicts.

? = inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true
SCID-RV (for DSM-5®) (Version 1.0.0) Premenstrual Dysphoric Disorder Mood Episodes w/o Specifier A.37

...did you feel very sad, down, depressed, or hopeless?

IF NO: How about feeling especially critical of yourself or that everything you did was wrong?

IF YES TO EITHER: Did this go away when your menstrual period began or shortly after?

...did you feel extremely anxious or tense or like you were keyed up or on edge?

IF YES: Did this go away when your menstrual period began or shortly after?

...did you feel very sad, down, depressed, or hopeless?

IF NO: How about feeling especially critical of yourself or that everything you did was wrong?

IF YES TO EITHER: Did this go away when your menstrual period began or shortly after?

3. Marked depressed mood, feelings of hopelessness, or self-deprecating thoughts. 1 2 3 A176

4. Marked anxiety, tension, and/or feelings of being keyed up or on edge. 1 2 3 A177

AT LEAST ONE "B" SYMPTOM IS CODED "3" 1 3 A178

Now I’m going to ask you about some other experiences that sometimes go along with these mood symptoms.

...did you lose interest in work or school, going out with friends, or in your hobbies?

IF YES: Did this go away when your menstrual period began or shortly after?

...did you find it hard to concentrate on things?

IF YES: Did this go away when your menstrual period began or shortly after?

...did you feel like your energy was very low or that you got tired very easily?

IF YES: Did this go away when your menstrual period began or shortly after?

...was your appetite increased? Did you have specific food cravings, like for chocolate or fried foods?

IF YES: Did this go away when your menstrual period began or shortly after?

1. Decreased interest in usual activities (e.g., work, school, friends, and hobbies). 1 2 3 A179

2. Subjective difficulty in concentration. 1 2 3 A180

3. Lethargy, easy fatigability, or marked lack of energy. 1 2 3 A181

4. Marked change in appetite; overeating; or specific food cravings. 1 2 3 A182

?=inadequate information 1=absent or false 2=subthreshold 3=threshold or true
SCID-RV (for DSM-5®) (Version 1.0.0)

Premenstrual Dysphoric Disorder

Mood Episodes w/o Specifier

A.38

...were you sleeping more than is usual for you or have difficulty sleeping? (How much sleep were you getting during that time?)

IF YES: Did this go away when your menstrual period began or shortly after?

5. Hypersomnia or insomnia. ? 1 2 3 A183

...were you feeling overwhelmed by everything or like your life was out of control?

IF YES: Did this go away when your menstrual period began or shortly after?

6. A sense of being overwhelmed or out of control. ? 1 2 3 A184

...did you have physical symptoms like breast tenderness or swelling, joint or muscle pain, or feeling bloated? Did you gain weight?

IF YES: Did these symptoms go away when your menstrual period began or shortly after?

7. Physical symptoms such as breast tenderness or swelling, joint or muscle pain, a sensation of “bloating,” or weight gain. ? 1 2 3 A185

AT LEAST ONE “C” SYMPTOM IS CODED “3.”

1 3 A186

GO TO NEXT MODULE

AT LEAST FIVE “B” AND “C” SYMPTOMS ARE CODED “3.”

1 3 A187

GO TO NEXT MODULE

IF UNCLEAR: Has this happened for most of your cycles in the past year?

Symptoms in criterion A-C must have been met for most menstrual cycles in the preceding year.

NOTE: Code “3” only if symptoms in criteria A-C have been met for 7 or more cycles in the past year.

? 1 2 3 A188

GO TO NEXT MODULE

?=inadequate information

1=absent or false

2=subthreshold

3=threshold or true
**IF UNKNOWN: What effect have (PMDD SXS) had on your life?**

ASK THE FOLLOWING QUESTIONS AS NEEDED TO RATE CRITERION D:

How have (PMDD SXS) affected your relationships or your interactions with other people? (Have they caused you any problems in your relationships with your family, romantic partner or friends?)

How have (PMDD SXS) affected your work/school? (How about your attendance at work or school? Have they affected the quality of your work/schoolwork?)

How have (PMDD SXS) affected your ability to take care of things at home? How about doing other things that are important to you like religious activities, physical exercise, or hobbies? Did you avoid doing anything because you felt like you weren’t up to it?

Have (PMDD SXS) affected any other important part of your life?

IF HAVE NOT INTERFERED WITH LIFE:

How much have you been bothered or upset by having (PMDD SXS)?

**IF HISTORY OF ANOTHER MENTAL DISORDER AND UNKNOWN:** Are these symptoms different from the symptoms you had from (PAST DISORDER)? Or is it just those same symptoms getting worse just before your period?

D. The symptoms are associated with clinically significant distress or interference with work, school, usual social activities, or relationships with others (e.g., avoidance of social activities; decreased productivity and efficiency at work, school, or home).

E. The disturbance is not merely an exacerbation of the symptoms of another disorder, such as Major Depressive Disorder, Panic Disorder, Persistent Depressive Disorder (Dysthymia), or a personality disorder (although it may co-occur with any of these disorders).

? = inadequate information  1 = absent or false  2 = subthreshold  3 = threshold or true
Since (1 YEAR AGO), when you were having these symptoms, were you physically ill?

IF YES: What did the doctor say?

Since (1 YEAR AGO), have you been taking any medications?

IF YES: Any change in the amount you were taking?

Since (1 YEAR AGO), have you been drinking or using any drugs?

G. [Primary Premenstrual Dysphoric Disorder:] The symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment) or another medical condition (e.g., hyperthyroidism).

IF THERE IS ANY INDICATION THAT THE SYMPTOMS MAY BE SECONDARY (I.E., A DIRECT PHYSIOLOGICAL CONSEQUENCE OF GMC OR SUBSTANCE), GO TO "GMC/SUBSTANCE" A.45, AND RETURN HERE TO MAKE A RATING OF "1" OR "3."

NOTE: Refer to lists of etiological medical conditions and substances/medications on page A.4.

PMDD CRITERIA A, B, C, D, E, AND G ARE CODED "3."

IF UNKNOWN: Have you ever kept a diary of your symptoms and how they relate to your cycles?

Indicate provisional vs. definite diagnosis: (circle the appropriate number)

1 - Provisional dx: The symptom pattern in Criterion A has NOT been confirmed by prospective daily ratings during at least two symptomatic cycles.

2 - Definite dx: Criterion F is present, i.e., the symptom pattern in Criterion A (i.e., at least five symptoms must be present in the final week before the onset of menses, start to improve within a few days after the onset of menses, and become minimal or absent in the week postmenses) has been confirmed by prospective daily ratings during at least two symptomatic cycles.
**GMC/SUBSTANCE CAUSING BIPOLAR AND RELATED SYMPTOMS**

**BIPOLAR AND RELATED DISORDER DUE TO ANOTHER MEDICAL CONDITION**

*IF SYMPTOMS NOT TEMPORALLY ASSOCIATED WITH A GENERAL MEDICAL CONDITION, CHECK HERE ____ AND GO TO *SUBSTANCE-INDUCED BIPOLAR AND RELATED DISORDER* A.43.

**CODE BASED ON INFORMATION ALREADY OBTAINED.**

A. A prominent and persistent period of abnormally elevated, expansive, or irritable mood and abnormally increased activity or energy that predominates in the clinical picture.

B/C. There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct physiological consequence of another medical condition and the disturbance is not better accounted for by another mental disorder.

**Did the (BIPOLAR SXS) change after (GMC) began? Did (BIPOLAR SXS) start or get much worse only after (GMC) began? How long after (GMC) began did (BIPOLAR SXS) start or get much worse?**

**NOTE:** The following factors should be considered and, if present, support the conclusion that a general medical condition is etiologic to the bipolar symptoms.

1) There is evidence from the literature of a well-established association between the general medical condition and the bipolar symptoms. (Refer to list of etiological medical conditions on page A.13.)

2) There is a close temporal relationship between the course of the bipolar symptoms and the course of the general medical condition.

3) The bipolar symptoms are characterized by unusual presenting features (e.g., late age-at-onset).

4) The absence of alternative explanations (e.g., bipolar symptoms as a psychological reaction to the stress of being diagnosed with a general medical condition).

**IF GMC HAS RESOLVED: Did the (BIPOLAR SXS) get better once the (GMC) got better?**

?=inadequate information 1=absent or false 2=subthreshold 3=threshold or true
SCID-RV (for DSM-5®) (Version 1.0.0)  
Bipolar Due to AMC  
Mood Episodes w/o Specifiers  A.42

**IF UNKNOWN:** What effect have (BIPOLAR SXS) had on your life?

**ASK THE FOLLOWING QUESTIONS AS NEEDED TO RATE CRITERION E:**

How have (BIPOLAR SXS) affected your relationships or your interactions with other people? (Have they caused you any problems in your relationships with your family, romantic partner or friends?)

How have they affected your work/school? (How about your attendance at work or school? Have they affected the quality of your work/schoolwork?)

How did (BIPOLAR SXS) affect your ability to take care of things at home? Did you need to go into the hospital to protect you from hurting yourself or someone else, or from doing something that could have caused serious financial or legal problems?

Have (BIPOLAR SXS) affected any other important part of your life?

**IF HAVE NOT INTERFERED WITH LIFE:** How much have (BIPOLAR SXS) bothered or upset you?

E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or necessitates hospitalization to prevent harm to self or others, or there are psychotic features.

NOTE: The D criterion (delirium rule-out) has been omitted.

BIPOLAR DISORDER DUE TO AMC CRITERIA A, B/C, AND E ARE CODED “3.”

CONTINUE ON NEXT PAGE

?=inadequate information  1=absent or false  2=subthreshold  3=threshold or true
SCID-RV (for DSM-5®) (Version 1.0.0) Substance-Induced Bipolar Mood Episodes w/o Specifiers A.43

**SUBSTANCE-/MEDICATION-INDUCED BIPOLAR DISORDER* INDUCED BIPOLAR DISORDER CRITERIA**

*IF SYMPTOMS ARE NOT TEMPORALLY ASSOCIATED WITH SUBSTANCE/MEDICATION USE, CHECK HERE ____ AND RETURN TO EPISODE BEING EVALUATED, CONTINUING WITH THE ITEM FOLLOWING "SYMPTOMS ARE NOT ATTRIBUTABLE TO THE PHYSIOLOGICAL EFFECTS OF A SUBSTANCE OR ANOTHER MEDICAL CONDITION" (SEE PAGE NUMBERS IN BOX TO THE RIGHT).*

**CODE BASED ON INFORMATION ALREADY OBTAINED.**

A. A prominent and persistent disturbance in mood that predominates in the clinical picture and is characterized by elevated, expansive, or irritable mood, with or without depressed mood, or markedly diminished interest or pleasure in all, or almost all activities.

B. There is evidence from the history, physical examination, or laboratory findings of both (1) and (2):

1. The symptoms in criterion A developed during or soon after substance intoxication or withdrawal or exposure to a medication.

2. The involved substance/medication is capable of producing the symptoms in Criterion A. NOTE: Refer to list of etiological substances/medications on page A.13.

C. The disturbance is NOT better accounted for by a bipolar or related disorder that is not substance-induced. Such evidence of an independent bipolar or related disorder could include the following:

   1) The symptoms precede the onset of the substance/medication use;
   2) The symptoms persist for a substantial period of time (e.g., about 1 month) after the cessation of acute withdrawal or severe intoxication; or
   3) There is other evidence suggesting the existence of an independent non-substance/medication-induced bipolar and related disorder (e.g., a history of recurrent non-substance/medication-related episodes).

**PAGE TO RETURN TO IN EPISODE BEING EVALUATED:**

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<tr>
<th>Criteria</th>
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**NOT SUBSTANCE-INDUCED. RETURN TO EPISODE BEING EVALUATED**

**ASK ANY OF THE FOLLOWING QUESTIONS AS NEEDED TO RULE OUT A NON-SUBSTANCE-INDUCED ETIOLOGY.**

**IF UNKNOWN: When did the (BIPOLAR SXS) begin? Were you already using (SUBSTANCE/MEDICATION) or had you just stopped or cut down your use?**

**IF UNKNOWN: How much (SUBSTANCE/MEDICATION) were you using when you began to have (BIPOLAR SXS)?**

**IF UNKNOWN: Which came first, the (SUBSTANCE/MEDICATION USE) or the (BIPOLAR SXS)?**

**IF UNKNOWN: Have you had a period of time when you stopped using (SUBSTANCE/MEDICATION)?**

**IF YES:** After you stopped using (SUBSTANCE/MEDICATION) did the (BIPOLAR SXS) go away or get better?

**IF YES:** How long did it take for them to get better? Did they go away within a month of stopping?

**IF UNKNOWN: Have you had any other episodes of (BIPOLAR SXS)?**

**IF YES:** How many? Were you using (SUBSTANCE/MEDICATION) at those times?

? = inadequate information  1 = absent or false  2 = subthreshold  3 = threshold or true
SCID-RV (for DSM-5®) (Version 1.0.0) Substance-Induced Bipolar Mood Episodes w/o Specifiers A.44

**IF UNKNOWN:** What effect have (BIPOLAR SXs) had on your life?

**ASK THE FOLLOWING QUESTIONS AS NEEDED TO RATE CRITERION E:**

**How have (BIPOLAR SXs) affected your relationships or your interactions with other people?** (Have they caused you any problems in your relationships with your family, romantic partner, or friends?)

**How have (BIPOLAR SXs) affected your work/school?** (How about your attendance at work or school? Have they affected the quality of your work/schoolwork?)

**How did (BIPOLAR SXs) affect your ability to take care of things at home?** Have you needed to go into the hospital to protect you from hurting yourself or someone else, or from doing something that could have caused serious financial or legal problems?

**Have (BIPOLAR SXs) affected any other important part of your life?**

**IF HAVE NOT INTERFERED WITH LIFE:** How much have (BIPOLAR SX) bothered or upset you?

---

**SUBSTANCE-INDUCED BIPOLAR DISORDER CRITERIA A, B, C, AND E ARE CODED “3.”**

Check here ____ if current in the past month.

Indicate context of development of mood symptoms:

1 - With onset during intoxication
2 - With onset during withdrawal

RETURN TO EPISODE BEING EVALUATED

? = inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true

82
**GMC/SUBSTANCE CAUSING DEPRESSIVE SYMPTOMS**

**DEPRESSIVE DISORDER DUE TO ANOTHER MEDICAL CONDITION**

*IF SYMPTOMS NOT TEMPORALLY ASSOCIATED WITH A GENERAL MEDICAL CONDITION, CHECK HERE ___ AND GO TO *SUBSTANCE-INDUCED DEPRESSIVE DISORDER* A.48*

**CODE BASED ON INFORMATION ALREADY OBTAINED.**

A. A prominent and persistent period of depressed mood or markedly diminished interest or pleasure in all, or almost all, activities that predominates in the clinical picture.

B./C. There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct physiological consequence of another medical condition and the disturbance is not better accounted for by another mental disorder.

**GO TO *SUBSTANCE-INDUCED* A.48**

---

**Did the (DEPRESSIVE SXS) change after (GMC) began? Did (DEPRESSIVE SXS) start or get much worse only after (GMC) began? How long after (GMC) began did (DEPRESSIVE SXS) start or get much worse?**

**IF GMC HAS RESOLVED: Did the (DEPRESSIVE SXS) get better once the (GMC) got better?**

**NOTE:** The following factors should be considered and, if present, support the conclusion that a general medical condition is etiologic to the depressive symptoms.

1) There is evidence from the literature of a well-established association between the general medical condition and the depressive symptoms. (Refer to list of etiological general medical conditions on page A.4.)

2) There is a close temporal relationship between the course of the depressive symptoms and the course of the general medical condition.

3) The depressive symptoms are characterized by unusual presenting features (e.g., late age-at-onset).

4) The absence of alternative explanations (e.g., depressive symptoms as a psychological reaction to the stress of being diagnosed with a general medical condition).

? = inadequate information

1 = absent or false

2 = subthreshold

3 = threshold or true

[83]
SCID-RV (for DSM-5®) (Version 1.0.0)

Depressive Disorder Due to AMC Mood Episodes w/o Specifier A.46

**IF UNKNOWN:** What effect have (DEPRESSIVE SX) had on your life?

ASK THE FOLLOWING QUESTIONS AS NEEDED TO RATE CRITERION E:

**How have (DEPRESSIVE SX) affected your relationships or your interactions with other people?** (Have they caused you any problems in your relationships with your family, romantic partner, or friends?)

**How have (DEPRESSIVE SX) affected your work/school?** (How about your attendance at work or school? Have they affected the quality of your work/schoolwork?)

**How have (DEPRESSIVE SX) affected your ability to take care of things at home?** How about doing simple everyday things like getting dressed, bathing, or brushing your teeth? How about doing other things that are important to you like religious activities, physical exercise, or hobbies? Did you avoid doing anything because you felt like you weren’t up to it?

**Have (DEPRESSIVE SX) affected any other important part of your life?**

**IF HAVE NOT INTERFERED WITH LIFE:** How much have (DEPRESSIVE SX) bothered or upset you?

E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

? 1 2 3

NOTE: The D criterion (delirium rule-out) has been omitted.
DEPRESSIVE DISORDER DUE TO AMC CRITERIA A, B/C, AND E ARE CODED “3.”

Check here ___ if current in the past month.

Specify if:
1 - With depressive features: Full criteria are not met for a major depressive episode.
2 - With major depressive-like episode: Full criteria are met (except Criterion C) for a major depressive episode.
3 - With mixed features: Symptoms of mania or hypomania are also present but do not predominate in the clinical picture.

CONTINUE ON NEXT PAGE

? = inadequate information
1 = absent or false
2 = subthreshold
3 = threshold or true
*SUBSTANCE-/MEDICATION-
INDUCED DEPRESSIVE
DISORDER*

IF SYMPTOMS NOT TEMPORALLY ASSOCIATED WITH SUBSTANCE/MEDICATION USE, CHECK
HERE ___ AND RETURN TO EPISODE BEING EVALUATED, CONTINUING WITH THE ITEM
FOLLOWING “SYMPTOMS ARE NOT ATTRIBUTABLE TO THE PHYSIOLOGICAL EFFECTS OF A
SUBSTANCE OR ANOTHER MEDICAL CONDITION” (SEE PAGE NUMBERS IN BOX TO THE
RIGHT).

CODE BASED ON INFORMATION ALREADY
OBTAINED.

IF UNKNOWN: When did the
(DEPRESSIVE SXS) begin? Were you
already using (SUBSTANCE/MEDICATION)
or had you just stopped or cut down
your use?

IF UNKNOWN: How much (SUBSTANCE/
MEDICATION) were you using when you
began to have (DEPRESSIVE SXS)?

A. A prominent and persistent disturbance in
mood that predominates in the clinical picture
and is characterized by depressed mood or
markedly diminished interest or pleasure in
all, or almost all, activities

B. There is evidence from the history, physical
examination, or laboratory findings of both
(1) and (2):

1. The symptoms in criterion A developed
during or soon after substance intoxication
or withdrawal or exposure to a medication

2. The involved substance/medication is
capable of producing the symptoms in
Criterion A. NOTE: refer to list of
etiological substances/medications on
page A.4.

PAGE TO RETURN TO IN
EPISODE BEING EVALUATED:
Current MDE A.4
Past MDE A.9
Current Persistent
Depressive Disorder A.31
Past Persistent
Depressive Disorder A.34
PMDD A.40
Other Specified
Depressive Disorder D.12

?=inadequate information 1=absent or false 2=subthreshold 3=threshold or true
ASK ANY OF THE FOLLOWING QUESTIONS AS NEEDED TO RULE OUT A NON-SUBSTANCE-INDUCED ETIOLOGY.

IF UNKNOWN: Which came first, the (SUBSTANCE/MEDICATION USE) or the (DEPRESSIVE SXS)?

IF UNKNOWN: Have you had a period of time when you stopped using (SUBSTANCE/MEDICATION)?

IF YES: After you stopped using (SUBSTANCE/MEDICATION) did the (DEPRESSIVE SXS) go away or get better?

IF YES: How long did it take for them to get better? Did they go away within a month of stopping?

IF UNKNOWN: Have you had any other episodes of (DEPRESSIVE SXS)?

IF YES: How many? Were you using (SUBSTANCE/MEDICATION) at those times?

IF UNKNOWN: What effect have (DEPRESSIVE SXS) had on your life?

ASK THE FOLLOWING QUESTIONS AS NEEDED TO RATE CRITERION E:

How have (DEPRESSIVE SXS) affected your relationships or your interactions with other people? (Have they caused you any problems in your relationships with your family, romantic partner or friends?)

How have (DEPRESSIVE SXS) affected your work/school? (How about your attendance at work or school? Have they affected the quality of your work/schoolwork?)

How have (DEPRESSIVE SXS) affected your ability to take care of things at home? How about doing simple everyday things like getting dressed, bathing, or brushing your teeth? How about doing other things that are important to you like religious activities, physical exercise, or hobbies? Did you avoid doing anything because you felt like you weren’t up to it?

Have (DEPRESSIVE SXS) affected any other important part of your life?

IF HAVE NOT INTERFERED WITH LIFE: How much have (DEPRESSIVE SXS) bothered or upset you?

C. The disturbance is NOT better accounted for by a depressive disorder that is not substance-induced. Such evidence of an independent depressive disorder could include the following:

NOTE: The following three statements constitute evidence that the depressive symptoms are not substance-induced. Code "1" if any are true. Code "3" only if none are true.

1) The symptoms precede the onset of the substance/medication use;
2) The symptoms persist for a substantial period of time (e.g., about 1 month) after the cessation of acute withdrawal or severe intoxication; or
3) There is other evidence suggesting the existence of an independent non-substance/medication-induced depressive disorder (e.g., a history of recurrent non-substance/medication-related episodes).

E. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

NOTE: the D criterion (delirium rule-out) has been omitted.

RETURN TO EPISODE BEING EVALUATED
SCID-RV (for DSM-5®) (Version 1.0.0)

Substance-Induced Depressive Mood Episodes w/o Specifiers A.50

SUBSTANCE-INDUCED DEPRESSIVE DISORDER

CRITERIA A, B, C, AND E ARE CODED “3.”

SUBSTANCE/MEDICATION-INDUCED DEPRESSIVE DISORDER

Check here ___ if current in the past month

Indicate context of development of mood symptoms:

1 – With onset during intoxication
2 – With onset during withdrawal

RETURN TO EPISODE BEING EVALUATED

?=inadequate information  1=absent or false  2=subthreshold  3=threshold or true
B/C. PSYCHOTIC SCREENING MODULE

NOTE: This module is for coding psychotic and associated symptoms that have been present at any point in the subject’s lifetime. It can be used for settings in which cases with primary psychotic symptoms are to be excluded i.e., psychotic symptoms that are not due to substance/medication use or to a general medical condition) and/or psychotic symptoms that occur outside the context of a Major Depressive or Manic Episode.

For each psychotic symptom coded “3,” describe the actual content and indicate the period of time during which the symptom was present. Moreover, for any psychotic symptom coded “3” determine whether the symptom is definitely “primary” or whether there is a possible or definite etiological substance (including medication) or general medical condition. Refer to page B/C.6 for a list of possible etiological general medical conditions and substances/medications.

The following questions may be useful if the Overview has not already provided the information.

Just before (PSYCHOTIC SXS) began, were you using drugs? ...were you taking any medications? ...did you drink much more than usual or stop drinking after you had been drinking a lot for a while? ...were you physically ill?

IF YES TO ANY: Has there been a time when you had (PSYCHOTIC SXS) and were not (USING DRUGS/TAKING MEDICATION/CHANGING YOUR DRINKING HABITS/ILL)?

DELUSIONS

Now I’d like to ask you about unusual experiences that people sometimes have.

A false belief based on incorrect inference about external reality that is firmly held 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. When a false belief involves a value judgment, it is regarded as a delusion only when the judgment is so extreme as to defy credibility. Code overvalued ideas (unreasonable and sustained beliefs that are maintained with less than delusional intensity) as “2.”

Has it ever seemed like people were talking about you or taking special notice of you? (What do you think they were saying about you?)

IF YES: Were you convinced they were talking about you or did you think it might have been your imagination?

Delusion of reference, i.e., events, objects, or other persons in the individual’s immediate environment are seen as having a particular and unusual significance.

DESCRIBE:

Did you ever have the feeling that something on the radio, TV, or in a movie was meant especially for you? (...not just that it was particularly relevant to you, but that it was specifically meant for you.)

Did you ever have the feeling that the words in a popular song were meant to send you a special message? (...not just that they were particularly relevant to you, but that they were specifically meant for you.)

Did you ever have the feeling that what people were wearing was intended to send you a special message?

Did you ever have the feeling that street signs or billboards had a special meaning for you?

?=Inadequate information  
1=Absent or false  
2=Subthreshold  
3=Threshold or true
SCID-RV (for DSM-5®) (Version 1.0.0) Psychotic Symptoms

**Persecutory delusion**, i.e., the central theme is that one (or someone to whom one is close to) is being attacked, harassed, cheated, persecuted, or conspired against.

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**Grandiose delusion**, i.e., content involves inflated worth, power, knowledge identity, or a special relationship to a deity or famous person.

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**Somatic delusion**, i.e., main content pertains to the appearance or functioning of one’s body.

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**Delusion of guilt**, i.e., a belief that a minor error in the past will lead to disaster, or 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) with which there can be no possible connection.

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**Jealous delusion**, i.e., that one’s sexual partner is unfaithful

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- **What about anyone going out of their way to give you a hard time, or trying to hurt you? (Tell me about that.)**
- **Have you ever had the feeling that you were being followed, spied on, manipulated, or plotted against?**
- **Did you ever have the feeling that you were being poisoned or that your food had been tampered with?**
- **Have you ever thought that you were especially important in some way, or that you had special powers or knowledge? (Tell me about that.)**
- **Did you ever believe that you had a special or close relationship with a celebrity or someone else famous?**
- **Have you ever been convinced that something was very wrong with your physical health even though your doctor said nothing was wrong...like you had cancer or some other disease? (Tell me about that.)**
- **Have you ever felt that something strange was happening to parts of your body?**
- **Have you ever felt that you had committed a crime or done something terrible for which you should be punished? (Tell me about that.)**
- **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?**
- **What about feeling responsible for a disaster such as a fire, flood, or earthquake?**
- **Have you ever been convinced that your spouse or partner was being unfaithful to you?**
  - IF YES: How did you know they were being unfaithful? (What clued you into this?)

? = Inadequate information    1 = Absent or false    2 = Subthreshold    3 = Threshold or true
SCID-RV (for DSM-5®) (Version 1.0.0)  

Psychotic Symptoms

Did you ever have a “secret admirer” who, when you tried to contact them, denied that they were in love with you? (Tell me about that.)

**Erotomanic delusion**, i.e., that another person, usually of higher status, is in love with the individual.

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Were you ever romantically involved with someone famous? (Tell me about that.)

Are you a religious or spiritual person?

**IF YES:** Have you ever had any religious or spiritual experiences that the other people in your religious or spiritual community have not experienced?

**IF YES:** Tell me about your experiences. (What did they think about these experiences of yours?)

**IF NO:** Have you ever felt that God, the devil, or some other spiritual being or higher power has communicated directly with you? (Tell me about that. Do others in your religious or spiritual community also have such experiences?)

**IF NO:** Have you ever felt that God, or the devil or some other spiritual being or higher power has communicated directly with you? (Tell me about that. Do others in your religious or spiritual community also have such experiences?)

Did you ever feel that someone or something outside yourself was controlling your thoughts or actions against your will? (Tell me about that.)

**Delusion of being controlled**, i.e., feelings, impulses, thoughts, or actions are experienced as being under the control of some external force rather than under one’s own control.

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Did you ever feel that certain thoughts that were not your own were put into your head? (Tell me about that.)

**Thought insertion**, i.e., that certain thoughts are not one’s own, but rather are inserted into one’s mind.

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What about thoughts being taken out of your head? (Tell me about that.)

**Thought withdrawal**, i.e., that one’s thoughts have been “removed” by some outside force.

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>?=Inadequate information 1=Absent or false 2=Subthreshold 3=Threshold or true
SCID-RV (for DSM-5®) (Version 1.0.0)

Did you ever feel as if your thoughts were being broadcast out loud so that other people could actually hear what you were thinking? (Tell me about that.)

Thought broadcasting, i.e., the delusion that one’s thoughts are being broadcast out loud so that others can perceive them.

Describe:

Did you ever believe that someone could read your mind? (Tell me about that.)

Other delusions (e.g., that others can read the person’s mind, a delusion that one has died several years ago).

Describe:

Hallucinations

A perception-like experience with the clarity and impact of a true perception, but without the external stimulation of the relevant sensory organ. The person may or may not have insight into the nonveridical nature of the hallucination (i.e., one hallucinating person may recognize the false sensory experience, whereas another may be convinced that the experience is grounded in reality).

Note: Code "2" for hallucinations that are so transient as to be without diagnostic significance. Code "1" for hypnagogic or hypnopompic hallucinations.

Did you ever hear things that other people couldn’t, such as noises, or the voices of people whispering or talking? (Were you awake at the time?)

If yes: What did you hear? How often did you hear it?

Auditory hallucinations, i.e., involving the perception of sound, most commonly of voice) when fully awake, heard either inside or outside of one’s head.

Describe:

Did you have visions or see things that other people couldn’t see? (Tell me about that. Were you awake at the time?)

Visual hallucinations, i.e., a hallucination involving sight, which may consist of formed images, such as of people or of unformed images, such as flashes of light.

Describe:

What about strange sensations on your skin, like feeling like something is creeping or crawling on or under your skin? How about the feeling of being touched or stroked? (Tell me about that.)

Tactile hallucinations, i.e., a hallucination involving the perception of being touched or of something being under one’s skin.

Describe

?=Inadequate information 1=Absent or false 2=Subthreshold 3=Threshold or true
SCID-RV (for DSM-5®) (Version 1.0.0)  

Psychotic Symptoms

What about having unusual sensations inside a part of your body, like a feeling of electricity? (Tell me about that.)

**Somatic hallucination**, i.e., a hallucination involving the perception of physical experience localized within the body (e.g., a feeling of electricity).

**DESCRIBE:**

How about eating or drinking something that you thought tasted bad or strange even though everyone else who tasted it thought it was fine? (Tell me about that.)

**Gustatory hallucinations**, i.e., a hallucination involving the perception of taste (usually unpleasant)

**DESCRIBE:**

What about smelling unpleasant things that other people couldn’t smell, like decaying food or dead bodies? (Tell me about that.)

**Olfactory hallucinations**, i.e., a hallucination involving the perception of odor

**DESCRIBE:**

**ANY ITEM CODED "3" IN "PRIMARY" SECTION**

Psychotic symptoms occur at times other than during mood episodes.

**NOTE:** Code "3" if psychotic symptoms have been present and either: 1) there have never been any Major Depressive or Manic Episodes, or 2) psychotic symptoms occurred outside of Major Depressive or Manic Episodes. Code ‘1” if psychotic symptoms have occurred only during Major Depressive or Manic Episodes.

**IF A MAJOR DEPRESSIVE OR MANIC EPISODE HAS EVER BEEN PRESENT: Has there ever been a time when you had (PSYCHOTIC SX) and you were not (depressed/high/irritable/OWN WORDS)?**

? = Inadequate information  
1 = Absent or false  
2 = Subthreshold  
3 = Threshold or true

EXPLORE DETAILS AND DESCRIBE DIAGNOSTIC SIGNIFICANCE:
**Etiological general medical conditions** include:

Neurological conditions (e.g., neoplasms, cerebrovascular disease, Huntington's disease, multiple sclerosis, epilepsy, auditory or visual nerve injury or impairment, deafness, migraine, central nervous system infections), endocrine conditions (e.g., hyper- and hypothyroidism, hyper- and hypoparathyroidism, hyper- and hypoadrenocorticism), metabolic conditions (e.g., hypoxia, hypercarbia, hypoglycemia), fluid or electrolyte imbalances, hepatic or renal diseases, and autoimmune disorders with central nervous system involvement (e.g., systemic lupus erythematosus).

**Etiological substances/medications** include:

Alcohol (during intoxication or withdrawal); cannabis (during intoxication); hallucinogens (during intoxication), phencyclidine (and related substances (during intoxication); inhalants (during intoxication); sedatives, hypnotics, and anxiolytics (during intoxication or withdrawal); and stimulants (including cocaine) (during intoxication);

Other substances and medications that can cause psychotic symptoms include anesthetics and analgesics, anticholinergic agents, anticonvulsants, antihistamines, antihypertensive and cardiovascular medications, antimicrobial medications, antiparkinsonian medications, chemotherapeutic agents (e.g., cyclosporine, procarbazine), corticosteroids, gastrointestinal medications, muscle relaxants, nonsteroidal anti-inflammatory medications, other over-the-counter medications (e.g., phenylephrine, pseudoephedrine), antidepressant medication, and disulfiram. Toxins include anticholinesterase, organophosphate insecticides, sarin and other nerve gases, carbon monoxide, carbon dioxide, and volatile substances such as fuel or paint.
E. SUBSTANCE USE DISORDERS

*PAST-12-MONTH ALCOHOL USE DISORDER*

- IF DENIES ANY LIFETIME ALCOHOL USE ON PAGE 6 OF PATIENT OVERVIEW (OR PAGE 4 OF NON-PATIENT OVERVIEW), CHECK HERE AND GO TO *NON-ALCOHOL SUBSTANCE USE DISORDERS* E.10

- IF ACKNOWLEDGES LIFETIME ALCOHOL USE DURING OVERVIEW AND IF UNKNOWN: Have you drunk alcohol at least six times in the past 12 months, that is, since (1 YEAR AGO)?

  - IF YES: Now I’d like to ask you some more questions about your drinking since (1 YEAR AGO)...
  - IF NO: GO TO *PRIOR-TO-PAST-12-MONTH ALCOHOL USE DISORDER* E.6.

A. A problematic pattern of alcohol use, leading to clinically significant impairment or distress, as manifested by at least two of the following occurring within a 12-month period:

NOTE: The DSM-IV examples that were omitted in DSM-5 have been restored here.

During the past year, have you found that once you started drinking you ended up drinking much more than you intended 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 intending to?

During the past year, have you wanted to stop, cut down, or control your drinking?

  - IF YES: How long did this desire to stop, cut down, or control your drinking last?
  - IF NO: During the past year, did you ever try to cut down, stop, or control your drinking? How successful were you? (Did you make more than one attempt to stop, cut down, or control your drinking?)

Have you spent a lot of time drinking, being drunk, or hung over? (How much time?)

1. Alcohol is often taken in larger amounts OR over a longer period than was intended.

2. There is a persistent desire OR unsuccessful efforts to cut down or control alcohol use.

3. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.

? = Inadequate information 1 = Absent or false 2 = Subthreshold 3 = Threshold or true
Have you had a strong desire or urge to drink in between those times when you were drinking? (Has there been a time when you had such strong urges to have a drink that you had trouble thinking about anything else?)

**IF NO:** How about having a strong desire or urge to drink when you were around bars or around people with whom you go drinking?

**During the past year, since (1 YEAR AGO), have you missed work or school or often arrived late because you were intoxicated, high, or very hung over?**

**IF NO:** How about doing a bad job at work or school, or failing courses or flunking out of school because of your drinking?

**IF NO:** How about getting in trouble at work or school because of your use of alcohol?

**IF NO:** How about not taking care of things at home because of your drinking, like making sure there is food and clean clothes for your family and making sure your children go to school and get medical care? How about not paying your bills?

**IF YES TO ANY:** How often?

Has your drinking caused problems with other people, such as family members, friends, or people at work? (Have you found yourself regularly getting into arguments about what happens when you drink too much? Have you gotten into physical fights when you were drunk?)

**IF YES:** Have you kept on drinking anyway?

Have you had to give up or reduce the time you spent at work or school, with family or friends, or on things you like to do (like sports, cooking, other hobbies) because you were drinking or hungover?

**During the past year, since (1 YEAR AGO), have you ever had a few drinks right before doing something that requires coordination and concentration like driving, boating, climbing on a ladder, or operating heavy machinery?**

**IF YES:** Would you say that the amount you had to drink affected your coordination or concentration so that it was more likely that you or someone else could have been hurt?

**IF YES AND UNKNOWN:** How many times? (When?)

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<th>Question</th>
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<td>4. Craving, or a strong desire or urge to use alcohol.</td>
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<td>5. Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home [(e.g., repeated absences or poor work performance related to alcohol use; alcohol-related absences, suspensions, or expulsions from school; neglect of children or household)].</td>
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<td>6. Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol [(e.g., arguments with spouse about consequences of intoxication, physical fights)].</td>
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<td>7. Important social, occupational, or recreational activities given up or reduced because of alcohol use.</td>
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<td>8. Recurrent alcohol use in situations in which it is physically hazardous [(e.g., driving an automobile or operating a machine when impaired by alcohol use)].</td>
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= Inadequate information  
1 = Absent or false  
2 = Subthreshold  
3 = Threshold or true
Has your drinking caused you any problems like making you very depressed or anxious? How about putting you in a “mental fog,” making it difficult for you to sleep, or making it so you couldn’t recall what happened while you were drinking?

Has your drinking caused significant physical problems or make a physical problem worse, like stomach ulcers, liver disease, or pancreatitis?

**IF YES TO EITHER OF ABOVE: Have you kept on drinking anyway?**

Have you found that you needed to drink much more in order to get the feeling you wanted than you did when you first started drinking?

- **IF YES:** How much more?
- **IF NO:** What about finding that when you drank the same amount, it had much less effect than before? (How much less?)

During the past year, since (1 YEAR AGO), have you had any withdrawal symptoms, in other words, feeling sick when you cut down or stopped drinking?

- **IF YES:** What symptoms did you have? (Sweating or a racing heart? Your hand[s] shaking? Trouble sleeping? Feeling nauseated or vomiting? Feeling agitated? Feeling anxious? How about having a seizure or seeing, feeling, or hearing things that weren’t really there?)
- **IF NO:** During the past year, have you ever started the day with a drink, or did you often drink or take some other drug or medication to keep yourself from getting the shakes or becoming sick?

9. Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol [(e.g., continued drinking despite recognition that an ulcer was made worse by alcohol consumption)].

10. Tolerance, as defined by either of the following:

- a. A need for markedly increased amounts of alcohol to achieve intoxication or desired effect.
- b. Markedly diminished effect with continued use of the same amount of alcohol.

11. Withdrawal, as manifested by either of the following:

- a. At least **TWO** of the following developing within several hours to a few days after the cessation of (or reduction in) alcohol use:
  - autonomic hyperactivity (e.g., sweating or pulse rate greater than 100 bpm)
  - increased hand tremor
  - insomnia
  - nausea or vomiting
  - psychomotor agitation
  - anxiety
  - generalized tonic-clonic seizures
  - transient visual, tactile, or auditory hallucinations or illusions
- b. Alcohol (or a closely related substance such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms.
AT LEAST TWO ALCOHOL USE DISORDER ITEMS CODED "3" DURING THE PERIOD OF THE PAST 12 MONTHS

GO TO *PRIOR-TO-PAST 12-MONTH ALCOHOL USE DISORDER* E.6

Indicate severity of Alcohol Use Disorder for past 12 months: (circle the appropriate number)
1 – Mild: Presence of 2–3 symptoms.
2 – Moderate: Presence of 4–5 symptoms.
3 – Severe: Presence of 6 or more symptoms.

CONTINUE WITH *PAST-12-MONTH ALCOHOL USE CHRONOLOGY* NEXT PAGE

?=Inadequate information  1=Absent or false  2=Subthreshold  3=Threshold or true
*PAST-12-MONTH ALCOHOL USE DISORDER CHRONOLOGY*

During the past 3 months, how much have you been drinking?

**IF HAD ANYTHING TO DRINK IN PAST 3 MONTHS:**
Has your drinking caused any problems for you in the past 3 months? (Problems like [ALCOHOL USE ITEMS CODED "3"]?)

Number of months prior to interview when the subject last had any Alcohol Use Disorder symptom (except for craving).

Check if In a controlled environment: The individual is [currently] in a controlled environment where access to alcohol is restricted.

Indicate remission: (circle the appropriate number)

1 – In early remission: After full criteria for Alcohol Use Disorder were previously met, none of the criteria for Alcohol Use Disorder have been met for at least 3 months but for less than 12 months (with the exception that Criterion A.4, “Craving, or a strong desire or urge to use alcohol,” may be met).

(Sustained Remission does not apply to Past 12-month Alcohol Use Disorder)

*AGE AT ONSET*

How old were you when you first had (LIST OF ALCOHOL USE DISORDER SXS CODED "3")?

Age at onset of Alcohol Use Disorder (CODE 99 IF UNKNOWN).

GO TO *PAST-12-MONTH NON-ALCOHOL SUBSTANCE USE DISORDER* E.10
NOTE: If an assessment of the severity of Alcohol Use Disorder prior to the past 12 months is needed, continue on next page instead of skipping to E.10

?=Inadequate information 1=Absent or false 2=Subthreshold 3=Threshold or true
**PRIOR-TO-PAST-12-MONTH ALCOHOL USE DISORDER**

*IF ALCOHOL USE PRIOR-TO-PAST-12 MONTHS IS NOT EXCESSIVE AND NON-PROBLEMATIC ACCORDING TO QUESTIONS ON PAGE 6 OF PATIENT OVERVIEW (OR PAGE 4 OF NON-PATIENT OVERVIEW), SCREEN FOR LIFETIME ALCOHOL USE THRESHOLD WITH THE FOLLOWING:*

Besides the past year, have you ever drunk alcohol at least six times in a 12-month period?

IF YES: When was that?

IF NEVER DRANK SIX TIMES IN 12-MONTH PERIOD, CHECK HERE ___ AND GO TO *PAST-12-MONTH NON-ALCOHOL SUBSTANCE USE DISORDERS* E.10.

Looking back over your life, if you had to pick a 12-month period when you were drinking the most or during which your drinking caused you the most problems, when would that have been?

**ALCOHOL USE DISORDER CRITERIA**

**A.** A problematic pattern of alcohol use, leading to clinically significant impairment or distress, as manifested by at least two of the following occurring within a 12-month period:

1. Alcohol is often taken in larger amounts OR over a longer period than was intended.

2. There is a persistent desire OR unsuccessful efforts to cut down or control alcohol use.

3. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.

4. Craving, or a strong desire or urge to use alcohol.

**Indicate month and year:** ___ / ___

=?=Inadequate information 1=Absent or false 2=Subthreshold 3=Threshold or true
During (12-MONTH PERIOD), did you ever miss work or school or often arrive late because you were intoxicated, high, or very hung over?

IF NO: How about doing a bad job at work or school, or failing courses or flunking out from school because of your drinking?

IF NO: How about getting in trouble at work or school because of your use of alcohol?

IF NO: How about not taking care of things at home because of your drinking, like making sure there is food and clean clothes for your family and making sure your children go to school and get medical care? How about not paying your bills?

IF YES TO ANY: How often?

During (12-MONTH PERIOD), did your drinking cause problems with other people, such as family members, friends, or people at work? (Did you find yourself regularly getting into arguments about what happens when you drink too much? Did you get into physical fights when you were drunk?)

IF YES: Did you keep on drinking anyway? (Over what period of time)?

During (12-MONTH PERIOD), did you have to give up or reduce the time you spent at work or school, with family or friends, or on things you like to do (like sports, cooking, other hobbies) because you were drinking or hungover?

During (12-MONTH PERIOD), did you have a few drinks right before doing something that required coordination and concentration like driving, boating, climbing on a ladder, or operating heavy machinery?

IF YES: Would you say that the amount you had to drink affected your coordination or concentration so that it was more likely that you or someone else could have been hurt?

IF YES AND UNKNOWN: How many times?

5. Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to alcohol use; alcohol-related absences, suspensions, or expulsions from school; neglect of children or household).

6. Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol (e.g., arguments with spouse about consequences of intoxication, physical fights).

7. Important social, occupational, or recreational activities given up or reduced because of alcohol use.

8. Recurrent alcohol use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by alcohol use).
SCID-RV (for DSM-5®) (Version 1.0.0) Prior-to-Past-12-Month Alcohol Use Substance Use Disorders E.8

Did your drinking cause you any problems like making you very depressed or anxious? How about putting you in a “mental fog,” making it difficult for you to sleep, or making it so you couldn’t recall what happened while you were drinking?

Did your drinking cause significant physical problems or make a physical problem worse, like stomach ulcers, liver disease, or pancreatitis?

**IF YES TO EITHER OF ABOVE:** Did you keep on drinking anyway?

**During (12-MONTH PERIOD), did you need to drink much more in order to get the feeling you wanted than you did when you first started drinking?**

- IF YES: How much more?
- IF NO: What about finding that when you drank the same amount, it had much less effect than before? (How much less?)

**During (12-MONTH PERIOD), did you ever have any withdrawal symptoms, in other words feeling sick when you cut down or stopped drinking?**

- IF YES: What symptoms did you have? (Sweating or a racing heart? Your hand[s] shaking? Trouble sleeping? Feeling nauseated or vomiting? Feeling agitated? Feeling anxious? How about having a seizure or seeing, feeling, or hearing things that weren’t really there?)
- IF NO: Did you ever start the day with a drink, or did you often drink or take some other drug or medication to keep yourself from getting the shakes or becoming sick?

9. Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol [(e.g., continued drinking despite recognition that an ulcer was made worse by alcohol consumption)].

10. Tolerance, as defined by either of the following:
   a. A need for markedly increased amounts of alcohol to achieve intoxication or desired effect.
   b. Markedly diminished effect with continued use of the same amount of alcohol.

11. Withdrawal, as manifested by either of the following:
   a. At least **TWO** of the following developing within several hours to a few days after the cessation of (or reduction in) alcohol use:
      - autonomic hyperactivity (e.g., sweating or pulse rate greater than 100 bpm)
      - increased hand tremor
      - insomnia
      - nausea or vomiting
      - psychomotor agitation
      - anxiety
      - generalized tonic-clonic seizures
      - transient visual, tactile, or auditory hallucinations or illusions
   b. Alcohol (or a closely related substance such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms.

? = Inadequate information  
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*PRIOR-TO-PAST-12-MONTH ALCOHOL USE DISORDER CHRONOLOGY*

REMISSION SPECIFIER FOR PAST ALCOHOL USE DISORDER

*Check _____ if In a controlled environment:* The individual is [currently] in an environment where access to alcohol is restricted.

*Indicate remission:* (circle the appropriate number)

1 – Not in remission (i.e., one Substance Use Disorder criterion has been present during the past 12 months)

2 – In sustained remission: After full criteria for Alcohol Use Disorder were previously met, none of the criteria for Alcohol Use Disorder have been met at any time during a period of 12 months or longer (with the exception that Criterion A.4, “Craving, or a strong desire or urge to use alcohol,” may be met).

*AGE AT ONSET*

*How old were you when you first had (LIST OF ALCOHOL USE DISORDER SXS CODED “3”)*? Age at onset of Alcohol Use Disorder (CODE 99 IF UNKNOWN) _____ _____

? = Inadequate information
1 = Absent or false
2 = Subthreshold
3 = Threshold or true
*PAST-12-MONTH NON-ALCOHOL SUBSTANCE USE DISORDER*

REVIEW HISTORY OF DRUG USE ON PAGES 7-8 OF PATIENT OVERVIEW (OR PAGES 5-6 OF NON-PATIENT OVERVIEW). IF DENIES ANY LIFETIME DRUG USE IN OVERVIEW, CHECK HERE ___ AND GO TO NEXT MODULE.

FOR DRUGS USED IN PAST 12 MONTHS: CODE "3" FOR EACH DRUG CLASS BELOW BASED ON CODING IN RIGHT HAND COLUMN OF OVERVIEW DRUG ASSESSMENT (PATIENT OVERVIEW PAGES 7-8 OR NON-PATIENT OVERVIEW PAGES 5-6). OTHERWISE, CODE "1" FOR THAT DRUG CLASS.

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E39  E40  E41  E42  E43  E44  E45  E46

IF ALL DRUG CLASSES CODED "1" FOR PERIOD OF PAST 12 MONTHS, CHECK HERE ___ AND GO TO *PRIOR-TO-PAST-12-MONTH NON-ALCOHOL SUBSTANCE USE DISORDER* E.26.

FOR ALL CLASSES CODED "3" ABOVE, CIRCLE THE APPROPRIATE COLUMN HEADERS (DRUG CLASS NAMES) ON PAGES E.11 TO E.18, BASED ON ONE OF THE FOLLOWING OPTIONS: (Indicate option used with a check mark in front of option)

___ OPTION #1: DETERMINE THE PRESENCE OF SUBSTANCE USE DISORDER IN PAST 12 MONTHS (SINGLE MOST PROBLEMATIC SUBSTANCE).

Which drug or medication caused you the most problems over the past 12 months, since (1 YEAR AGO)?
Which one did you use the most? (Which was your "drug of choice"?)

START WITH THE DRUG CLASS THAT WAS MOST PROBLEMATIC OR USED THE MOST. RETURN HERE IF CRITERIA ARE NOT MET FOR INITIAL DRUG CLASS AND THERE IS ALSO EVIDENCE OF CLINICALLY SIGNIFICANT USE OF OTHER DRUG CLASSES. ASK ABOUT EACH DRUG CLASS IN SEQUENCE UNTIL EITHER THE CRITERIA ARE MET FOR A SUBSTANCE USE DISORDER IN THE PAST 12 MONTHS OR ELSE NONE OF THE DRUG CLASSES MEET CRITERIA.

___ OPTION #2: DETERMINE PRESENCE OF THE THREE SUBSTANCE CLASSES MOST HEAVILY USED OR MOST PROBLEMATIC IN THE PAST 12 MONTHS.

Which drugs or medications caused you the most problems over the past 12 months, since (1 YEAR AGO)?
Which ones did you use the most? (Which were your "drugs of choice"?)

___ OPTION #3: DETERMINE PRESENCE OF SUBSTANCE USE DISORDER IN THE PAST 12 MONTHS FOR ALL DRUG CLASSES ABOVE SCREENING THRESHOLD.

?=Inadequate information  1=Absent or false  2=Subthreshold  3=Threshold or true
Now I’d like to ask you some more questions about your use of (DRUG CLASS[ES] CIRCLED IN COLUMN HEADERS) in the past 12 months, since (1 YEAR AGO).

FOR EACH CRITERION, ASK QUESTIONS FOR CIRCLED DRUG CLASS(ES) ONLY:

During the past year, have you found that once you started using (DRUG) you ended up using much more than you intended to? For example, you planned to have (SMALL AMOUNT OF DRUG) but you ended up having much more. (Tell me about that. How often did that happen?)

IF NO: What about using (DRUG) for a much longer period of time than you were intending to?

1. The substance is often taken in larger amounts OR over a longer period than was intended.

During the past year, have you wanted to stop or cut down using (DRUG), or control your use of (DRUG)?

IF YES: How long did this desire to stop, cut down, or control your use of (DRUG) last?

IF NO: During the past year, did you ever try to cut down, stop, or control your use of (DRUG)? How successful were you? (Did you make more than one attempt to stop, cut down, or control your use of [DRUG]?)

2. There is a persistent desire OR unsuccessful efforts to cut down or control substance use.

|=Inadequate information  1=Absent or false  2=Subthreshold  3=Threshold or true
During the past year, have you spent a lot of time getting (DRUG) or using (DRUG) or has it taken a lot of time for you to get over the effects of (DRUG)? (How much time?)

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3. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.

Have you had a strong desire or urge to use (DRUG) in between those times when you were using (DRUG)? (Has there been a time when you had such strong urges to use (DRUG) that you had trouble thinking about anything else?)

*IF NO: How about having a strong desire or urge to use (DRUG) when you were around people with whom you used (DRUG)?*

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4. Craving, or a strong desire or urge to use the substance.

?=Inadequate information 1=Absent or false 2=Subthreshold 3=Threshold or true
SCID-RV (for DSM-5®) (Version 1.0.0)

Past-12-Month Substance Use

5. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home [(e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household)].

6. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance [(e.g., arguments with spouse about consequences of intoxication, physical fights)].

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IF NOT ALREADY KNOWN: During the past year, has your use of (DRUG) caused problems with other people, such as with family members, friends, or people at work? (Have you found yourself regularly getting into arguments about your [DRUG] use? Have you gotten into physical fights when you were taking [DRUG]?)

IF YES: Have you kept on using (DRUG) anyway?

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?=Inadequate information        1=Absent or false        2=Subthreshold        3=Threshold or true
Have you had to give up or reduce the time you spent at work or school, with family or friends, or on your hobbies because you were using (DRUG) instead?

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During the past year, have you ever gotten high before doing something that requires coordination and concentration like driving, boating, climbing on a ladder, or operating heavy machinery?

**IF YES:** (FOR SUBSTANCES OTHER THAN STIMULANTS): Would you say that your use of (DRUG) affected your coordination or concentration so that it was more likely that you or someone else could have been hurt?

**IF YES:** (FOR STIMULANTS ONLY): Would you say that your being high on (STIMULANT) made you drive recklessly like driving very fast or taking unnecessary risks?

**IF YES TO EITHER AND UNKNOWN:** How many times?

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? = Inadequate information   1 = Absent or false   2 = Subthreshold   3 = Threshold or true
Has your use of (DRUG) during the past year caused you any problems like making you very depressed, irritable, anxious, paranoid, or extremely agitated? What about triggering panic attacks, making it difficult for you to fall or stay asleep, putting you into a “mental fog,” or making it so you couldn’t recall what happened while you were using (DRUG)?

Has your use of (DRUG) caused physical problems, like heart palpitations, coughing or trouble breathing, constipation, or skin infections?

**IF YES TO EITHER OF ABOVE:** Have you kept on using (DRUG) anyway?

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Have you found that you needed to use much more (DRUG) in order to get the feeling you wanted than when you first started using it?

**IF YES:** How much more?

**IF NO:** What about finding that when you used the same amount, it had much less effect than before?

**IF PRESCRIBED MEDICATION:** Were you taking (DRUG) exactly as your doctor told you to? (Did you ever take more of it than was prescribed or run out of your prescription early? Did you ever go to more than one doctor in order to get the amount of medication you wanted?)

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9. Substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance ([e.g., recurrent cocaine use despite recognition of cocaine-related depression]).

10. Tolerance, as defined by either of the following:

a. A need for markedly increased amounts of the substance to achieve intoxication or desired effect.

b. Markedly diminished effect with continued use of the same amount of the substance.

**Note:** If opioids, sedative/hypnotic/anxiolytic medications, or stimulant medications are taken solely under appropriate medical supervision, this criterion is not considered to be met.

?=Inadequate information 1=Absent or false 2=Subthreshold 3=Threshold or true
THE FOLLOWING ITEM DOES NOT APPLY TO INHALANTS, PCP, OR HALLUCINOGENS.

During the past year, have you had any withdrawal symptoms, in other words felt sick when you cut down or stopped using (DRUG)?

- **IF YES**: What symptoms did you have? Refer to list of withdrawal symptoms on E.28.

- **IF NO**: After not using (DRUG) for a few hours or more, did you sometimes use it or something like it to keep yourself from getting sick with (WITHDRAWAL SXS)?

11. Withdrawal, as manifested by either of the following:
   
   a. The characteristic withdrawal syndrome for the substance (see page E.28).
   
   b. The same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms

**Note**: This criterion does not apply to inhalants, PCP, or hallucinogens.

**Note**: If opioids, sedatives/hypnotics/anxiolytics medications, or stimulant medications are taken solely under appropriate medical supervision, this criterion is not considered to be met.
### PAST-12-MONTH NON-ALCOHOL SUBSTANCE USE DISORDER CODING

**Indicate Severity:**
1 – Mild: 2-3 sxs.
2 – Moderate: 4-5 sxs.
3 – Severe: 6+ sxs.

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<tr>
<th>Sedative/Hypnotic Anxiolytic</th>
<th>Cannabis</th>
<th>Stimulants</th>
<th>Opioid</th>
<th>Inhalants</th>
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**IF SELECTED OPTION #1 (MOST PROBLEMATIC SUBSTANCE):**

*IF THERE IS EVIDENCE OF CLINICALLY SIGNIFICANT USE OF ANOTHER DRUG CLASS IN PAST 12 MONTHS (OTHER THAN THOSE ALREADY ASSESSED), GO BACK TO E.11 AND RE-ASSESS CRITERIA FOR THAT DRUG CLASS. OTHERWISE, GO TO *PRIOR-TO-PAST-12-MONTH NON-ALCOHOL SUBSTANCE USE DISORDER* E.26.

**IF SELECTED OPTION #2 (THREE MOST HEAVILY USED) OR OPTION #3 (ALL DRUG CLASSES AT USE THRESHOLD):**

*IF NO DRUG CLASSES CODED "3" (I.E., NO CURRENT [PAST YEAR] SUBSTANCE USE DISORDER), GO TO *PRIOR-TO-PAST-12-MONTH NON-ALCOHOL SUBSTANCE USE DISORDER* E.26.

**INDICATE SPECIFIC NAME(S) OF SUBSTANCE(S) FOR WHICH CRITERIA WERE MET (I.E., CODED "3" ABOVE):**

- Sedatives, Hypnotics, or Anxiolytics
- Cannabis
- Stimulants (including cocaine)
- Opioids
- Inhalants
- Phencyclidine and Related Substances
- Hallucinogens
- Other or Unknown

?=Inadequate information  1=Absent or false  2=Subthreshold  3=Threshold or true
*PAST-12-MONTH NON-ALCOHOL SUBSTANCE USE CHRONOLOGY*

**AT LEAST ONE SUBSTANCE USE DISORDER SYMPTOM (EXCEPT FOR CRAVING) IN THE PAST 3 MONTHS**

**SEDATIVE/HYPNOTIC ANXIOLYTIC**
- 3
- E160

**CANNABIS**
- 1
- E165

**STIMULANTS**
- 1
- E169

**OPOID**
- 1
- E173

**INHALANTS**
- 1
- E177

**PCP**
- 1
- E181

**HALLUCINOGENS**
- 1
- E185

**OTHER/UNKNOWN**
- 1
- E189

**Indicate remission status:** (circle number in box to the right)

1 = Early remission.

No criteria (except craving) met for at least 3 months but for less than 12 months

(Sustained remission does not apply to past 12 month Substance Use Disorder)

**Indicate (with a check) if In a controlled environment:** If the individual is [currently] in an environment where access to substances is restricted.

**When did you last have (ANY SXS OF SUBSTANCE USE DISORDER)?**

[Number of months prior to interview when the subject last had any Substance Use Disorder symptom (except for craving).]

**How old were you when you first had (LIST OF SUBSTANCE USE DISORDER SXS CODED "3")?**

**Indicate (check here) ___ If [currently] On maintenance therapy:** If the individual is taking a prescribed agonist medication such as methadone or buprenorphine and none of the criteria for Opioid Use Disorder have been met for that class of medication (except tolerance to, or withdrawal from, the agonist). This category also applies to those individuals being maintained on a partial agonist, an agonist/antagonist, or a full antagonist such as oral naltrexone or depot naltrexone.

E193

?-Inadequate information 1=Absent or false 2=Subthreshold 3=Threshold or true

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PRIOR-TO-PAST-12-MONTH NON-ALCOHOL SUBSTANCE USE DISORDER

FOR DRUG CLASSES USED PRIOR TO THE PAST 12 MONTHS DURING THE SUBJECT’S LIFETIME AND FOR WHICH CRITERIA ARE NOT ALREADY MET IN THE PAST 12 MONTHS FOR SUBSTANCE USE DISORDER (I.E., NOT CODED "3" ON PAGE E.17), CODE "3" FOR EACH DRUG CLASS BELOW BASED ON CODING IN THE MIDDLE COLUMN OF OVERVIEW DRUG ASSESSMENT (PATIENT OVERVIEW PAGES 7–8 OR NON-PATIENT OVERVIEW PAGES 5–6). OTHERWISE CODE "1."

NOTE: IF AN ASSESSMENT OF THE SEVERITY OF ALL NON-ALCOHOL SUBSTANCE USE DISORDERS PRIOR TO THE PAST 12 MONTHS IS NEEDED, IGNORE ABOVE INSTRUCTION TO CODE "3" ONLY FOR DRUG CLASSES FOR WHICH CRITERIA ARE NOT ALREADY CURRENT MET, I.E., CODE "3" FOR EACH DRUG CLASS BASED ON CODING IN MIDDLE COLUMN FOR ALL DRUG CLASSES.

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IF ALL OF THE ABOVE DRUG CLASSES ARE CODED "1,” CHECK HERE ___ AND GO TO NEXT MODULE.

FOR ALL CLASSES CODED “3” ABOVE, CIRCLE THE APPROPRIATE COLUMN HEADERS (DRUG CLASS NAMES) ON PAGES E.20 TO E.25, BASED ON ONE OF THE FOLLOWING OPTIONS: (Indicate option used with a check mark in front of option.)

___ OPTION #1: DETERMINE THE LIFETIME PRESENCE OF SUBSTANCE USE DISORDER (SINGLE MOST PROBLEMATIC SUBSTANCE):

Which drug or medication caused you the most problems? Which one did you use the most? (Which was your “drug of choice?”)

START WITH THE DRUG CLASS THAT WAS MOST PROBLEMATIC OR USED THE MOST. RETURN HERE IF CRITERIA ARE NOT MET FOR INITIAL DRUG CLASS AND THERE IS ALSO EVIDENCE OF CLINICALLY SIGNIFICANT USE OF OTHER DRUG CLASSES. ASK ABOUT EACH DRUG CLASS IN SEQUENCE UNTIL EITHER THE CRITERIA ARE MET FOR A SUBSTANCE USE DISORDER OR ELSE NONE OF THE DRUG CLASSES MEET CRITERIA.

___ OPTION #2: DETERMINE LIFETIME PRESENCE OF THE THREE SUBSTANCE CLASSES MOST HEAVILY USED OR MOST PROBLEMATIC:

Which drugs or medications caused you the most problems? Which ones did you use the most? (Which were your “drugs of choice?”)  

___ OPTION #3: DETERMINE LIFETIME PRESENCE OF SUBSTANCE USE DISORDER FOR ALL DRUG CLASSES ABOVE SCREENING THRESHOLD.

?=Inadequate information  1=Absent or false  2=Subthreshold  3=Threshold or true
FOR EACH DRUG CLASS CIRCLED IN COLUMN HEADERS: Looking back over your life, if you had to pick a 12-month period when you used (CIRCLED DRUG CLASS) the most or during which your use of (CIRCLED DRUG CLASS) caused you the most problems, when would that be?

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NON-ALCOHOL SUBSTANCE USE DISORDER CRITERIA

Now I’d like to ask you some more questions about your use of (CIRCLED DRUG CLASSES) during (12-MONTH PERIODS SELECTED ABOVE).

FOR EACH CRITERION, ASK QUESTIONS FOR CIRCLED DRUG CLASS(ES) ONLY:

A. A problematic pattern of substance use leading to clinically significant impairment or distress, as manifested by at least two of the following occurring within a 12-month period:

1. The substance is often taken in larger amounts OR over a longer period than was intended.

   IF NO: What about using (DRUG) for a much longer period of time than you were intending to?

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1=Absent or false
2=Subthreshold
3=Threshold or true

?=Inadequate information
### SCID-RV (for DSM-5®) (Version 1.0.0)

**Prior-to-Past-12 month Substance Use Disorders** E.21

**During** (12-MONTH PERIOD) did you want to stop or cut down using (DRUG), or control your use of (DRUG)?

- **IF YES:** How long did this desire to stop, cut down, or control your use of (DRUG) last?
- **IF NO:** Did you try to cut down, stop, or control your use of (DRUG)? How successful were you? (Did you make more than one attempt to stop, cut down, or control your use of [DRUG]?)

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During (12-MONTH PERIOD), did you spend a lot of time getting (DRUG) or using (DRUG) or has it taken a lot of time for you to get over the effects of (DRUG)? (How much time?)

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2. There is a persistent desire OR unsuccessful efforts to cut down or control substance use.

3. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.

? = Inadequate information  
1 = Absent or false  
2 = Subthreshold  
3 = Threshold or true
During (12-MONTH PERIOD), did you have a strong desire or urge to use (DRUG) in between those times when you were using (DRUG)? (Was there a time when you had such strong urges to use [DRUG] that you had trouble thinking about anything else?)

**IF NO:** How about having a strong desire or urge to use (DRUG) when you were around people with whom you used (DRUG)?

### Table: Dependence Symptoms for Various Substances

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During (12-MONTH PERIOD), did you ever miss work or school or often arrived late because you were intoxicated, high, or recovering from the night before?

**IF NO:** How about doing a bad job at work or school, or failing courses or flunking out of school because of your use of (DRUG)?

**IF NO:** How about getting into trouble at work or school because of your use of (DRUG)?

**IF NO:** How about not taking care of things at home because of your use of (DRUG), like making sure there is food and clean clothes for your family and making sure your children go to school and get medical care? How about not paying your bills?

**IF YES TO ANY:** How often?

### Table: Other Dependence Symptoms for Various Substances

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4. Craving, or a strong desire or urge to use the substance.

5. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home [(e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household)].

\[? = \text{Inadequate information} \quad 1 = \text{Absent or false} \quad 2 = \text{Subthreshold} \quad 3 = \text{Threshold or true}\]
During (12-MONTH PERIOD), did your use of (DRUG) cause problems with other people, such as with family members, friends, or people at work? (Did you find yourself regularly getting into arguments about your [DRUG] use? Did you get into physical fights when you were taking [DRUG]?)

**IF YES:** Did you keep on using (DRUG) anyway?

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During (12-MONTH PERIOD), did you give up or reduce the time you spent at work or school, with family or friends, or on your hobbies because you were using (DRUG) instead?

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• = Inadequate information  
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6. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance [(e.g., arguments with spouse about consequences of intoxication, physical fights)].

7. Important social, occupational, or recreational activities given up or reduced because of substance use.
During (12-MONTH PERIOD), did you ever use (DRUG) before doing something that required coordination and concentration like driving, boating, climbing on a ladder, or operating heavy machinery?

**IF YES: (FOR SUBSTANCES OTHER THAN STIMULANTS):** Would you say that your use of (DRUG) affected your coordination or concentration so that it was more likely that you or someone else could have been hurt?

**IF YES: (FOR STIMULANTS ONLY):** Would you say that your being high on (STIMULANTS) made you drive recklessly like driving very fast or taking unnecessary risks?

**IF YES TO EITHER AND UNKNOWN:** How many times? (When did this happen?)

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During (12-MONTH PERIOD), did your use of (DRUG) cause you any problems like making you very depressed, irritable, anxious, paranoid, or extremely agitated? What about triggering panic attacks, making it difficult for you to fall or stay asleep, putting you into a "mental fog," or making it so you couldn’t recall what happened while you were using (DRUG)?

**Did your use of (DRUG) cause physical problems, like heart palpitations, coughing or trouble breathing, constipation, or skin infections?**

**IF YES TO EITHER OF ABOVE:** Did you keep on using (DRUG) anyway?

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During (12-MONTH PERIOD), did you need to use much more (DRUG) in order to get the feeling you wanted than when you first started using it?

IF YES: How much more?

IF NO: What about finding that when you used the same amount, it had much less effect than before?

IF PRESCRIBED MEDICATION: Were you taking (DRUG) exactly as your doctor told you to? (Did you ever take more of it than was prescribed or run out of your prescription early? Did you ever go to more than one doctor in order to get the amount of medication you wanted?)

10. Tolerance, as defined by either of the following:

a. A need for markedly increased amounts of the substance to achieve intoxication or desired effect.

b. Markedly diminished effect with continued use of the same amount of the substance.

Note: If opioids, sedative/hypnotics/anxiolytics medications, or stimulant medications are taken solely under appropriate medical supervision, this criterion is not considered to be met.

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THE FOLLOWING ITEM DOES NOT APPLY TO INHALANTS, PCP, OR HALLUCINOGENS.

During (12-MONTH PERIOD), did you ever have any withdrawal symptoms, in other words felt sick when you cut down or stopped using (DRUG)?

IF YES: What symptoms did you have? REFER TO LIST OF WITHDRAWAL SYMPTOMS ON E.28.

IF NO: After not using (DRUG) for a few hours or more, did you sometimes use it or something like it to keep yourself from getting sick with (WITHDRAWAL SYMPTOMS)?

11. Withdrawal, as manifested by either of the following:

a. The characteristic withdrawal syndrome for the substance (see page E.28).

b. The same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms

Note: This criterion does not apply to inhalants, PCP, or hallucinogens.

Note: If opioids, sedative/hypnotics/anxiolytic medications, or stimulant medications are taken solely under appropriate medical supervision, this criterion is not considered to be met.

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? = Inadequate information 1 = Absent or false 2 = Subthreshold 3 = Threshold or true
### PRIOR-TO-PAST-12-MONTH NON-ALCOHOL SUBSTANCE USE DISORDER CODING

#### AT LEAST TWO SUBSTANCE USE DISORDER ITEMS CODED "3" DURING THE SAME 12 MONTH PERIOD

<table>
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<th>Subclass</th>
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#### YEAR THAT CRITERIA WERE LAST MET:

**Indicate Severity:** (circle the appropriate number in box to the right)

1 - Mild: 2-3 sxs.
2 - Moderate: 4-5 sxs.
3 - Severe: 6+ sxs.

**ONLY FOR CLASSES CODED "3": How old were you when you first had** (LIST OF SUBSTANCE USE DISORDER SXS CODED "3")

**Indicate (with a check) ____ if On maintenance therapy:** If the individual is taking a prescribed agonist medication such as methadone or buprenorphine and none of the criteria for Opioid Use Disorder have been met for that class of medication (except tolerance to, or withdrawal from, the agonist). This category also applies to those individuals being maintained on a partial agonist, an agonist/antagonist, or a full antagonist such as oral naltrexone or depot naltrexone.

**IF SELECTED OPTION #1 (MOST PROBLEMATIC SUBSTANCE):**

IF THERE IS EVIDENCE OF CLINICALLY SIGNIFICANT USE OF ANOTHER DRUG CLASS PRIOR TO THE PAST 12 MONTHS (OTHER THAN THOSE ALREADY ASSESSED), GO BACK TO E.20 AND RE-ASSESS CRITERIA FOR THAT DRUG CLASS. OTHERWISE, GO TO NEXT PAGE TO RECORD SPECIFIC NAMES OF SUBSTANCES AND REMISSION STATUS.

**IF SELECTED OPTION #2 (THREE MOST HEAVILY USED) OR OPTION #3 (ALL DRUG CLASSES AT USE THRESHOLD):**

IF NO DRUG CLASSES CODED "3" (I.E., NO SUBSTANCE USE DISORDER PRIOR TO PAST 12 MONTHS), GO TO THE NEXT PAGE TO RECORD SPECIFIC NAMES OF SUBSTANCES AND REMISSION STATUS.

?=Inadequate information 1=Absent or false 2=Subthreshold 3=Threshold or true
SCID-RV (for DSM-5®) (Version 1.0.0) Prior-to-Past-12-Month Substance Use Disorders E.27

INDICATE SPECIFIC NAME(S) OF SUBSTANCE(S) FOR WHICH CRITERIA WERE MET PRIOR TO PAST 12 MONTHS (I.E., CODED "3" ABOVE):

Sedatives, Hypnotics, or Anxiolytics
Cannabis
Stimulants (including cocaine)
Opioids
Inhalants
Phencyclidine and Related Substances
Hallucinogens
Other and Unknown

Indicate ___ if In a controlled environment: If the individual is [currently] in an environment where access to substances is restricted.

Indicate current remission status: (circle the appropriate number)
0 – Not in remission (i.e., one Substance Use criterion has been present in the past 12 months)
2 – In sustained remission: After full criteria for Substance Use Disorder were previously met, none of the criteria for Substance Use Disorder have been met at any time during the past 12 months or longer (with the exception that Criterion A.4, "Craving, or a strong desire or urge to use substance," may be met).

?=Inadequate information 1=Absent or false 2=Subthreshold 3=Threshold or true
LIST OF WITHDRAWAL SYMPTOMS (FROM DSM-5 CRITERIA)

Listed below are the characteristic withdrawal syndromes for those classes of psychoactive substances for which a withdrawal syndrome has been identified. (NOTE: A specific withdrawal syndrome has not been identified for PCP, HALLUCINOGENS, OR INHALANTS). Withdrawal symptoms may occur following the cessation of prolonged moderate or heavy use of a psychoactive substance or a reduction in the amount used.

SEDATIVES, HYPNOTICS, AND ANXIOLYTICS:
Two (or more) of the following, developing within several hours to a few days after cessation of (or reduction in) sedative, hypnotic, or anxiolytic use, that has been prolonged:
1. Autonomic hyperactivity (e.g., sweating or pulse rate greater than 100 bpm).
2. Hand tremor.
3. Insomnia.
4. Nausea or vomiting.
5. Transient visual, tactile, or auditory hallucinations or illusions.
6. Psychomotor agitation.
7. Anxiety.

CANNABIS:
Three (or more) of the following signs and symptoms developing within approximately one week after cessation of cannabis use that has been heavy and prolonged (i.e., usually daily or almost daily use over a period of at least a few months):
1. Irritability, anger, or aggression.
2. Nervousness or anxiety.
3. Sleep difficulty (e.g., insomnia, disturbing dreams).
4. Decreased appetite or weight loss.
5. Restlessness.
6. Depressed mood.
7. At least one of the following physical symptoms causing significant discomfort: abdominal pain, shakiness/tremors, sweating, fever, chills, or headache.

STIMULANTS/COCaine:
Dysphoric mood AND two (or more) of the following physiological changes, developing within a few hours to several days after cessation of (or reduction in) prolonged amphetamine-type substance, cocaine, or other stimulant use:
1. Fatigue.
2. Vivid, unpleasant dreams.
3. Insomnia or hypersomnia.
4. Increased appetite.
5. Psychomotor retardation or agitation.

OPIOIDS:
Three (or more) of the following, developing within minutes to several days after cessation of (or reduction in) opioid use that has been heavy and prolonged (i.e., several weeks or longer) or after administration of an opioid antagonist after a period of opioid use:
1. Dysphoric mood.
2. Nausea or vomiting.
4. Lacrimation or rhinorrhea (runny nose)
5. Pupillary dilation, piloerection ("goose bumps"), or sweating.
6. Diarrhea.
7. Yawning.
8. Fever.
9. Insomnia.
F. ANXIETY DISORDERS

*PANIC DISORDER*

IF SCREENING QUESTION #1 ANSWERED "NO," SKIP TO *AGORAPHOBIA* F.8.

IF QUESTION #1 ANSWERED "YES":

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.

IF SCREENER NOT USED: 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?

Tell me about that.

When was the last bad one?

What was it like? How did it begin?

IF UNKNOWN: Did the symptoms come on suddenly?

IF YES: How long did it take from when it began to when it got really bad? (Did it happen within a few minutes?)

A panic attack is an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes.

Note: The abrupt surge can occur from a calm state or an anxious state.

During that attack...

...did your heart race, pound or skip?

1. Palpitations, pounding heart, or accelerated heart rate.

...did you sweat?

2. Sweating.

...did you tremble or shake?

3. Trembling or shaking.

...were you short of breath? (Have trouble catching your breath? Feel like you were being smothered?)

4. Sensations of shortness of breath or smothering.

...did you feel as if you were choking?

5. Feelings of choking.

...did you have chest pain or pressure?

6. Chest pain or discomfort.

...did you have nausea or upset stomach or the feeling that you were going to have diarrhea?

7. Nausea or abdominal distress.

...did you feel dizzy, unsteady, or like you might faint?

8. Feeling dizzy, unsteady, lightheaded or faint.

...did you have flushes, hot flashes, or chills?

9. Chills or heat sensations.

?=Inadequate information 1=Absent or false 2=Subthreshold 3=Threshold or true
During that attack...

10. Paresthesias (numbness or tingling sensations)

11. Derealization (feelings of unreality) or depersonalization (being detached from oneself).

IF NO: How about feeling that everything around you was unreal or that you were in a dream?

12. Fear of losing control or "going crazy."


AT LEAST FOUR ITEMS CODED "3" AND REACHED THEIR PEAK WITHIN MINUTES

Besides the one you just described, have you had any other attacks which had even more of the symptoms that I just asked you about?

IF YES, GO BACK TO PAGE F.1 AND ASSESS THE SYMPTOMS OF THAT ATTACK.

IF NO: GO TO *AGORAPHOBIA* F.8

Have any of these attacks ever come on out of the blue—in situations where you didn’t expect to be nervous or uncomfortable?

IF YES: What was going on when the attack(s) happened? (What were you doing at the time? Were you already nervous or anxious at the time or rather were you relatively calm or relaxed?)

IF NO: How about the very first one you had. What were you doing at the time? (Were you already nervous or anxious at the time or rather were you relatively calm or relaxed?)

IF ATTACK IS UNEXPECTED: How many of these kinds of attacks have you had? (At least two?)

A. Recurrent unexpected panic attacks.

GO TO *EXPECTED PANIC ATTACKS* F.7

CONTINUE ON NEXT PAGE

?=Inadequate information 1=Absent or false 2=Subthreshold 3=Threshold or true
After any of these attacks...

...were you concerned or worried that you might have another attack or worried that you would feel like you were having a heart attack again, or worried that you would lose control or go crazy?

**IF YES:** How long did that concern or worry last? (Did it last at least a month? Nearly every day?)

...did you do anything differently because of the attacks (like avoiding certain places or not going out alone)? (What about avoiding certain activities like exercise? What about things like always making sure you're near a bathroom or exit?)

**IF YES:** How long did that last? (As long as a month?)

B. At least one of the attacks has been followed by 1 month (or more) of one or both of the following:

1. Persistent concern or worry about additional attacks or their consequences (e.g., losing control, having a heart attack, “going crazy”).

2. A significant maladaptive change in behavior related to the attacks (e.g., behaviors designed to avoid having panic attacks, such as avoidance of exercise or unfamiliar situations).

CRITERION B.1 OR B.2 CODED “3”

GO TO *AGORA-PHOBIA* F.8
IF UNKNOWN: When did your panic attacks start?

Just before you began having panic attacks, were you taking any drugs, caffeine, diet pills, or other medicines?

(How much coffee, tea, or caffeinated beverages do you drink a day?)

Just before the attacks, were you physically ill?

IF YES: What did the doctor say?

C. [Primary Anxiety Disorder:] The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism, cardiopulmonary disorders).

IF THERE IS ANY INDICATION THAT PANIC ATTACKS MAY BE SECONDARY (I.E., A DIRECT PHYSIOLOGICAL CONSEQUENCE OF A GMC OR SUBSTANCE/MEDICATION), GO TO *GMC/SUBSTANCE* F.33, AND RETURN HERE TO MAKE A RATING OF "1" OR "3."

Etiological medical conditions include: endocrine disease (e.g., hyperthyroidism, pheochromocytoma, hypoglycemia, hyperadrenocortisolism), cardiovascular disorders (e.g., congestive heart failure, pulmonary embolism, arrhythmia such as atrial fibrillation), respiratory illness (e.g., chronic obstructive pulmonary disease, asthma, pneumonia), metabolic disturbances (e.g., vitamin B12 deficiency, porphyria), and neurological illness (e.g., neoplasms, vestibular dysfunction, encephalitis, seizure disorders).

Etiological substances/medications include: alcohol (I/W), caffeine (I), cannabis (I), opioids (W), phencyclidine (I), other hallucinogens (I), inhalants, and stimulants (including cocaine) (I/W), sedatives, hypnotics, and anxiolytics (W); anesthetics and analgesics, sympathomimetics or other bronchodilators, anticholinergics, insulin, thyroid preparations, oral contraceptives, antihistamines, antiparkinsonian medications, corticosteroids, antihypertensive and cardiovascular medications, anticonvulsants, lithium carbonate, antipsychotic medications, antidepressant medications, and exposure to heavy metals and toxins such as organophosphate insecticide, nerve gases, carbon monoxide, carbon dioxide, volatile substances such as gasoline and paint.

IF NECESSARY, RETURN TO THIS ITEM AFTER COMPLETING MODULES FOR OC AND RELATED DISORDERS AND TRAUMA- AND STRESS-RELATED DISORDERS.

D. The disturbance is not better explained by another mental disorder (e.g., the panic attacks do not occur only in response to feared social situations, as in Social Anxiety Disorder; in response to circumscribed phobic objects or situations, as in Specific Phobia; in response to obsessions, as in Obsessive-Compulsive Disorder; in response to reminders of traumatic events, as in Posttraumatic Stress Disorder; or in response to separation from attachment figures, as in Separation Anxiety Disorder).

? 1 3

CONTINUE WITH NEXT ITEM

? = Inadequate information 1 = Absent or false 2 = Subthreshold 3 = Threshold or true
**PANIC DISORDER CHRONOLOGY**

*NOTE: IF LIFETIME ASSESSMENT ALREADY SUGGESTS THE PRESENCE OF PANIC ATTACKS DURING THE CURRENT MONTH, ASK THE FOLLOWING QUESTIONS ONLY IF NEEDED.*

Since (1 MONTH AGO) how many panic attacks have you had?

In the past month...

...have you been concerned or worried that you might have another attack or worried that you would feel like you were having a heart attack again, or worried that you would lose control or go crazy?

**IF YES:** Did you feel that way for most of the time since (1 MONTH AGO)?

...have you done anything differently because of the attacks (like avoiding certain places or not going out alone)? (What about avoiding certain activities like exercise? What about things like always making sure you’re near a bathroom or exit?)

**IF YES:** Did you feel that way for most of the time since (1 MONTH AGO)?

**CURRENT PANIC DISORDER**

CRITERIA A AND B.1 OR B.2 CODED “3” FOR PAST MONTH.

IF UNKNOWN: How old were you when you first started having panic attacks?

Age at onset of Panic Disorder (CODE 99 IF UNKNOWN).

? = Inadequate information  
1 = Absent or false  
2 = Subthreshold  
3 = Threshold or true
**PAST PANIC DISORDER**

When did you last have (ANY SXS OF PANIC DISORDER)?

Number of months prior to interview when last had a symptom of Panic Disorder

IF UNKNOWN: How old were you when you first started having panic attacks?

Age at onset of Panic Disorder (CODE 99 IF UNKNOWN).

GO TO *AGORA-PHOBIA* F.8
*EXPECTED PANIC ATTACKS*

IF THERE HAS BEEN ONLY A SINGLE UNEXPECTED PANIC ATTACK, GO TO *AGORAPHOBIA*, F.8 (CONTINUE ON THE NEXT PAGE).

In what kinds of situations did you have the attack(s)?

.... for example, did they occur when you were already anxious about something, like a social situation, or when you had to face something that you were afraid of?

Were you (depressed/OWN WORDS) at the time?

Were you (high/irritable/OWN WORDS) at the time?

Were you drinking or taking any drugs or medications?

Were you physically ill?

Indicate types of situations during which attack(s) occurred: (Check all that apply; page numbers indicate where "With panic attacks" specifier is coded):

___ Depressive thoughts (in MDD, page D.18, in Bipolar Disorder, in context of Major Depressive Episode, page D.16, and Persistent Depressive Disorder, page A.32)

___ Manic or hypomanic symptoms (in context of Manic Episode, pages D.15, in context of hypomanic episode, page D.16)

___ Social situations (in Social Anxiety Disorder, page F.17)

___ Phobic situations (in Specific Phobia, page F.22)

___ Chronic generalized anxiety and worry (in current GAD page F.26)

___ Separation from attachment figures (in Separation Anxiety Disorder, page Opt-F.4)

___ Due to a substance/medication (in Substance-induced Anxiety Disorder, F.36)

___ Due to another medical condition (in Anxiety Disorder due to AMC), F.34

___ Obsession/compulsion-related (in OCD, page G.6)

___ Hoarding-related (in Hoarding, page Opt-G.5)

___ Body Dysmorphic-Disorder-related (in BDD, page Opt-G.9)

___ Exposure to reminder of trauma (in Acute Stress Disorder, page L.10; in PTSD, page L.19)

Refer to back the above list of situations when coding the "With panic attacks" specifier included in the assessment of the respective disorders (page numbers indicate the page on which the panic attacks specifier is coded).

GO TO *AGORAPHOBIA*, F.8 (CONTINUE ON THE NEXT PAGE)
*AGORAPHOBIA*

IF SCREENING QUESTION #2 ANSWERED "NO," SKIP TO *SOCIAL ANXIETY DISORDER* F.14

IF QUESTION #2 ANSWERED "YES": 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.

IF SCREENER NOT USED: 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?

Tell me about the situations that you’ve been afraid of.

IF UNKNOWN: Have you been afraid of, or anxious about, travelling in taxi cabs, buses, trains, ships or planes?

IF UNKNOWN: How about being in open spaces, like parking lots, outdoor marketplaces, or bridges?

IF UNKNOWN: How about being in enclosed places like stores, movie theaters, or shopping malls?

IF UNKNOWN: How about standing in a line or being in a crowd?

IF UNKNOWN: How about being outside of the house alone?

A. Marked fear or anxiety about two (or more) of the following five situations:

1. Using public transportation (e.g., [taxi cabs], buses, trains, ships, planes).

2. Being in open spaces (e.g., parking lots, marketplaces, bridges).

3. Being in enclosed places (e.g., shops, theaters, cinemas).

4. Standing in line or being in a crowd.

5. Being outside of the home alone.

AT LEAST TWO ITEMS ARE CODED "3"

?=Inadequate information 1=Absent or false 2=Subthreshold 3=Threshold or true
Agoraphobia

Why did you avoid (SITUATIONS CODED “3”) (What were you afraid would happen?)

(Were you afraid that it might be hard for you to get out of the situation if you absolutely needed to...like if you suddenly developed a panic attack?)

(Or developing something else that would be embarrassing like losing control of your bladder or bowels or vomiting?)

(Or becoming impaired in some way like by falling or passing out?)

(How about being worried that there would be nobody there to help you in case these kinds of things happened?)

Have you almost always felt frightened or anxious when you were in (SITUATIONS CODED “3” ABOVE)?

C. The agoraphobic situations almost always provoke fear or anxiety.

D. The agoraphobic situations are actively avoided, require the presence of a companion, or are endured with intense fear or anxiety.

E. The fear or anxiety is out of proportion to the actual danger posed by the agoraphobic situations and the sociocultural context.

NOTE: Code “3” if situations do not pose danger or if fear or anxiety is out of proportion to actual danger or sociocultural context.

GO TO *SOCIAL ANXIETY DISORDER* F.14

GO TO *SOCIAL ANXIETY DISORDER* F.14

GO TO *SOCIAL ANXIETY DISORDER* F.14

SCID-RV (for DSM-5®) (Version 1.0.0) Anxiety Disorders F.9

? 1 2 3 F50

GO TO *SOCIAL ANXIETY DISORDER* F.14
SCID-RV (for DSM-5®) (Version 1.0.0)  

Agoraphobia  

F. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.

G. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

IF A GENERAL MEDICAL CONDITION CHARACTERIZED BY INCAPACITATING SYMPTOMS IS PRESENT:  Is your avoidance of (SITUATION) related to your (MEDICAL CONDITION)? (Tell me about it.  How often has [INCAPACITATING SYMPTOM] actually happened in [AVOIED SITUATION]?)

H. If another medical condition (e.g., inflammatory bowel disease, Parkinson’s disease) is present, the fear, anxiety, or avoidance is clearly excessive.

IF UNKNOWN:  What effect have (AGORAPHOBIC SXS) had on your life?

ASK THE FOLLOWING QUESTIONS AS NEEDED TO RATE CRITERION G:

How have (AGORAPHOBIC SXS) affected your relationships or your interactions with other people? (Have they caused any problems in your relationships with your family, romantic partner or friends?)

How have (AGORAPHOBIC SXS) affected your ability to work, take care of your family or household needs, or be involved in things that are important to you like religious activities, physical exercise, or hobbies?

Have (AGORAPHOBIC SXS) affected any other important part of your life?

IF HAVE NOT INTERFERED WITH FUNCTIONING:

How much have you been bothered or upset by having (AGORAPHOBIC SXS)?

Inadequate information  1=Absent or false  2=Subthreshold  3=Threshold or true
Agoraphobia

I. The fear, anxiety, or avoidance is not better explained by the symptoms of another mental disorder—for example, the symptoms are not confined to Specific Phobia, situational type; do not involve only social situations (as in Social Anxiety Disorder); and are not related exclusively to obsessions (as in Obsessive-Compulsive Disorder), perceived defects or flaws in physical appearance (as in Body Dysmorphic Disorder), reminders of traumatic events (as in Posttraumatic Stress Disorder), or fear of separation (as in Separation Anxiety Disorder).

NOTE: Consider a diagnosis of Specific Phobia if fear is limited to one or only a few specific situations, or a diagnosis of Social Anxiety Disorder if fear is limited to social situations.

AGORAPHOBIA CRITERIA A, B, C, D, E, F, G, H, AND I ARE CODED "3."

? 1 3 F57

GO TO *SOCIAL ANXIETY DISORDER* F.14

AGORAPHOBIA

1 3 F58

GO TO *SOCIAL ANXIETY DISORDER* F.14

AGORAPHOBIA
**AGORAPHOBIA CHRONOLOGY**

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

Since (6 MONTHS AGO), 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?

Since (6 MONTHS AGO), have you ever gone out of your way to avoid these situations?

IF NO: Have you been only able to go into one of these situations if you are with someone you know?

IF NO: When you have had to be in one of these situations, have you felt intensely afraid or anxious?

During the past six months, since (6 MONTHS AGO), what effect have (AGORAPHOBIC SXS) had on your life?

IF HAVE NOT INTERFERED WITH FUNCTIONING:
During the past 6 months, since (6 MONTHS AGO), how much have you been bothered or upset by having (AGORAPHOBIC SXS)?

**CURRENT AGORAPHOBIA**

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

IF UNKNOWN: How old were you when you first started having (SXS OF AGORAPHOBIA)?

Age at onset of Agoraphobia (CODE 99 IF UNKNOWN)

? = Inadequate information  1 = Absent or false  2 = Subthreshold  3 = Threshold or true
*PAST AGORAPHOBIA*

**When did you last have** (ANY SXS OF AGORAPHOBIA)?

Number of months prior to interview when last had a symptom of Agoraphobia

____ ____ ____  F64

**IF UNKNOWN: How old were you when you first started having** (SXS OF AGORAPHOBIA)?

Age at onset of Agoraphobia (CODE 99 IF UNKNOWN)

____ ____  F65

GO TO *SOCIAL ANXIETY DISORDER* F.14 (NEXT PAGE)
**SOCIAL ANXIETY DISORDER**

**SOCIAL ANXIETY DISORDER CRITERIA**

1. **IF SCREENING QUESTIONS #3 AND #4 ARE BOTH ANSWERED "NO," SKIP TO **SPECIFIC PHOBIA** F.19.**

2. **IF QUESTION #3 ANSWERED "YES":**
   You’ve said that you have been especially anxious or afraid in social situations, like having a conversation or meeting unfamiliar people.

3. **IF QUESTION #4 ANSWERED "YES":**
   You’ve [also] said that there are things that you have been afraid or felt very uncomfortable doing in front of other people, like speaking, eating, writing, or using a public bathroom.

4. **IF SCREENER NOT USED:**
   Have you been especially nervous or anxious in social situations like having a conversation or meeting unfamiliar people?

   **IF NO:**
   Is there anything that you have been afraid to do or felt very uncomfortable doing in front of other people, like speaking, eating, writing, or using a public bathroom?

**IF YES TO ANY OF ABOVE:**
Tell me about that. Give me some examples of when this has happened. (Situations like having a conversation, meeting people you don’t know, being observed eating, drinking or going to the bathroom or performing in front of others?)

A. Marked fear or anxiety about one or more social situations in which the person is exposed to possible scrutiny by others. Examples include social interactions (e.g., having a conversation, meeting unfamiliar people), being observed (e.g., eating or drinking), and performing in front of others (e.g., giving a speech).

   NOTE: Code "1" if fear or anxiety is limited to public speaking and is within normal limits.

   **What were you afraid would happen when you were in (SOCIAL OR PERFORMANCE SITUATION)?** (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?)

B. The individual fears that he or she will act in a way or show anxiety symptoms that will be negatively evaluated (i.e., will be humiliating or embarrassing; will lead to rejection or offend others).

   **Have you almost always felt frightened when you would be in (FEARED SOCIAL OR PERFORMANCE SITUATIONS)?**

C. The social situations almost always provoke fear or anxiety.

**? = Inadequate information 1 =Absent or false 2=Subthreshold 3=Threshold or true**
SCID-RV (for DSM-5®) (Version 1.0.0) Social Anxiety Disorder

**Social Anxiety Disorder**

**Anxiety Disorders** F.15

**IF UNKNOWN:** Did you go out of your way to avoid (FEARED SOCIAL OR PERFORMANCE SITUATIONS)?

**IF NO:** How hard was it for you to be in (FEARED SOCIAL SITUATION)?

**IF UNKNOWN:** What would you say would be the likely outcome of (PERFORMING POORLY IN SOCIAL SITUATIONS)? (Were these situations actually dangerous in some way, like avoiding being bullied or tormented by someone?)

**IF UNCLEAR:** How long have (SXs of SOCIAL ANXIETY DISORDER) lasted? (Have they lasted for at least 6 months or more?)

**IF UNKNOWN:** What effect have (SOCIAL ANXIETY SXs) had on your life?

**ASK THE FOLLOWING QUESTIONS AS NEEDED TO RATE CRITERION G:**

How have (SOCIAL ANXIETY SXs) affected your ability to have friends or meet new people? (How about dating?) How have (SOCIAL ANXIETY SXs) affected your interactions with other people, especially unfamiliar people?

How have (SOCIAL ANXIETY SXs) affected your ability to do things at school or at work that require interacting with other people? (How about making presentations or giving talks?)

Have you avoided going to school or to work if you think you will be put in a situation which makes your uncomfortable?

How have (SOCIAL ANXIETY SXs) affected your ability to work, take care of your family or household needs, or be involved in things that are important to you like religious activities, physical exercise, or hobbies?

Have (SOCIAL ANXIETY SXs) affected any other important part of your life?

**IF HAVE NOT INTERFERED WITH FUNCTIONING:** How much you been bothered or upset by having (SOCIAL ANXIETY SXs)?

? = Inadequate information  
1 = Absent or false  
2 = Subthreshold  
3 = Threshold or true
SCID-RV (for DSM-5®) (Version 1.0.0)

IF UNKNOWN: When did you begin having (SOCIAL ANXIETY SXS)?

Just before you began having (SOCIAL ANXIETY SXS), were you taking any drugs, caffeine, diet pills, or other medicines?

(How much coffee, tea, or caffeinated beverages did you drink a day?)

Just before (SOCIAL ANXIETY SXS) began, were you physically ill?

IF YES: What did the doctor say?

NOTE: Refer to list of etiological medical conditions or substances/medications on page F.4.

IF NECESSARY, RETURN TO THIS ITEM AFTER COMPLETING MODULES FOR OC AND RELATED DISORDERS.

IF A GENERAL MEDICAL CONDITION OR MENTAL DISORDER CHARACTERIZED BY POTENTIALLY EMBARRASSING SYMPTOMS IS PRESENT: Has your avoidance of (SOCIAL SITUATIONS) been related to your (MEDICAL CONDITION OR MENTAL DISORDER)?

IF YES: How have you dealt with your condition?

H. [Primary Anxiety Disorder:] The fear, anxiety, or avoidance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

IF THERE IS ANY INDICATION THAT THE ANXIETY MAY BE SECONDARY (I.E., A DIRECT PHYSIOLOGICAL CONSEQUENCE OF GMC OR SUBSTANCE), GO TO *GMC/SUBSTANCE* F.33, AND RETURN HERE TO MAKE A RATING OF "1" OR "3."

I. The fear, anxiety, or avoidance is not better explained by the symptoms of another mental disorder such as Panic Disorder, Separation Anxiety Disorder, Body Dysmorphic Disorder, or Autism Spectrum Disorder.

J. 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.

SOCIAL ANXIETY DISORDER CRITERIA A, B, C, D, E, F, G, H, I AND J ARE CODED "3."

? = Inadequate information  1 = Absent or false  2 = Subthreshold  3 = Threshold or true

CONTINUE WITH NEXT ITEM
SCID-RV (for DSM-5®) (Version 1.0.0)

**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)?**

**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)?**

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

**IF HAVE NOT 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)?**

**CURRENT SOCIAL ANXIETY DISORDER**

**CRITERIA A, D, AND G CODED "3" FOR PAST 6 MONTHS**

**IF UNKNOWN:** How old were you when you first started having (SXS OF SOCIAL ANXIETY DISORDER)?

Age at onset of Social Anxiety Disorder (CODE 99 IF UNKNOWN)

Specify if:

___ Performance only: if the fear is restricted to speaking or performing in public

Specify if:

**IF UNKNOWN:** Have you had any panic attacks in the past month?

___ With panic attacks: if one or more panic attacks in the past month occurring in the context of current Social Anxiety Disorder (see page F.7) and criteria have never been met for Panic Disorder

**GO TO *SPECIFIC PHOBIA* F.19**

*=Inadequate information  1=Absent or false  2=Subthreshold  3=Threshold or true
*PAST SOCIAL ANXIETY DISORDER*

**When did you last have** (ANY SXS OF SOCIAL ANXIETY DISORDER)?

Number of months prior to interview when last had a symptom of Social Anxiety Disorder

____  ____  ____  

*IF UNKNOWN: How old were you when you first started having** (SXS OF SOCIAL ANXIETY DISORDER)?

Age at onset of Social Anxiety Disorder (CODE 99 IF UNKNOWN)

____  ____

GO TO *SPECIFIC PHOBIA*  F.19
(NEXT PAGE)
**SPECIFIC PHOBIA*  

**SPECIFIC PHOBIA CRITERIA**

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**IF SCREENING QUESTION #5 ANSWERED "NO," SKIP TO *CURRENT GENERALIZED ANXIETY DISORDER* F.24.**

**IF QUESTION #5 ANSWERED "YES":**

You’ve said that there are other things that have made you especially anxious or afraid, like flying, seeing blood, getting a shot, heights, closed places, or certain kinds of animals or insects...

**IF SCREENER NOT USED: Are there any other things that have made you especially anxious or afraid, like flying, seeing blood, getting a shot, heights, closed places, or certain kinds of animals or insects?**

Tell me about that.

**A.** Marked fear or anxiety about a specific object or situation (e.g., flying, heights, animals, receiving an injection, seeing blood).

Have you almost always immediately felt frightened or anxious when you were (CONFRONTED WITH PHOBIC STIMULUS)?

**B.** The phobic object or situation almost always provokes immediate fear or anxiety.

Did you go out of your way to avoid (PHOBIC STIMULUS)? (Are there things you didn’t do because of this fear that you would otherwise have done?)

**IF NO:** How hard was it for you when (CONFRONTED WITH PHOBIC STIMULUS)?

**IF PHOBIC STIMULUS IS POSSIBLY DANGEROUS:** How dangerous would you say it actually is to (BE EXPOSED TO PHOBIC STIMULUS)?

**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.

Do you think that you have been more afraid of (PHOBIC STIMULUS) than you should have been given the actual danger?

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NOTE: Code “3” if objects or situations do not pose danger or if fear or anxiety is out of proportion to actual danger or sociocultural context.

**SCREEN Q#5**

<table>
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<th>YES</th>
<th>NO</th>
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</table>

F88

**IF NO:** GO TO *CURRENT GENERALIZED ANXIETY DISORDER* F.24

F89

GO TO *CURRENT GENERALIZED ANXIETY DISORDER* F.24

F90

GO TO *CURRENT GENERALIZED ANXIETY DISORDER* F.24

F91

GO TO *CURRENT GENERALIZED ANXIETY DISORDER* F.24

F92

GO TO *CURRENT GENERALIZED ANXIETY DISORDER* F.24

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? = Inadequate information  
1 = Absent or false  
2 = Subthreshold  
3 = Threshold or true
SCID-RV (for DSM-5®) (Version 1.0.0)  Specific Phobia  Anxiety Disorders F.20

**IF UNKNOWN:** How long have you had these fears? (For 6 months or more?)

E. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.

IF UNKNOWN: What effect have (PHOBIC SXS) had on your life?

ASK THE FOLLOWING QUESTIONS AS NEEDED TO RATE CRITERION F:

How have (PHOBIC SXS) affected your relationships with your family, romantic partner or friends?

How have (PHOBIC SXS) affected your work/school? (How about your attendance at work or school?)

How about doing other things that are important to you like religious activities, physical exercise, or hobbies?

**IF BLOOD-INJECTION-INJURY TYPE:** Have you avoided going to the dentist or doctor because of (PHOBIC SXS)? (How has this affected your health?)

Have (PHOBIC SXS) affected any other important part of your life?

**IF HAVE NOT INTERFERED WITH LIFE:** How much have you been bothered or upset by having (PHOBIC SXS)?

**IF NECESSARY, RETURN TO THIS ITEM AFTER COMPLETING MODULES FOR OC AND RELATED DISORDERS AND TRAUMA- AND STRESS-RELATED DISORDERS.**

F. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

G. The disturbance is not better explained by the symptoms of another mental disorder, including fear, anxiety, and avoidance of situations associated with panic like symptoms or other incapacitating symptoms (as in Agoraphobia), objects or situations related to obsessions (as in Obsessive-Compulsive Disorder) reminders of traumatic events (as in Posttraumatic Stress Disorder), separation from home or attachment figures (as in Separation Anxiety Disorder) or social situations (as in Social Anxiety Disorder).

? = Inadequate information  1 = Absent or false  2 = Subthreshold  3 = Threshold or true
SCID-RV (for DSM-5®) (Version 1.0.0)

**Specific Phobia Chronology**

Specific Phobia Criteria A, B, C, D, E, F, and G are coded “3.”

1. Inadequate information
2. Absent or false
3. Subthreshold
4. Threshold or true

*SPECIFIC PHOBIA CHRONOLOGY*

**NOTE:** If lifetime assessment already suggests the presence of specific phobia 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 (phobic situations mentioned above)?

A. [During the past 6 months,] marked fear or anxiety about a specific object or situation.

In the past 6 months, have you gone out of your way to avoid (phobic stimulus)? (Have there been things you didn’t do because of this fear that you would otherwise have done?)

IF NO: In the past 6 months, how hard has it been for you when (confronted with phobic stimulus)?

In the past 6 months, since (6 MONTHS AGO) what effect have (phobic sx’s) had on your life?

IF DOES NOT INTERFERE WITH LIFE: In the past 6 months, since (6 MONTHS AGO) how much have you been bothered or upset by having (phobic sx’s)?

C. [During the past 6 months,] the phobic situation(s) is actively avoided, or endured with intense fear or anxiety.

D. [During the past 6 months,] the fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

1. Absent or false
2. Subthreshold
3. Threshold or true

? = Inadequate information
*CURRENT SPECIFIC PHOBIA*

CRITERIA A, C, AND F CODED “3” FOR PAST 6 MONTHS

Age at onset of Specific Phobia (CODE 99 IF UNKNOWN)

IF UNKNOWN: How old were you when you first started having (SXS of Specific Phobia)?

Specify if: (Check all that apply)

___ Animal (e.g., spiders, insects, dogs)

___ Natural environment (includes heights, storms, water)

___ Blood-injection-injury (e.g., needles, invasive medical procedures)

___ Situational (includes airplanes, elevators, enclosed places)

___ Other type (e.g., situations that might lead to choking or vomiting)
 Specify: __________________

Specify if:

IF UNKNOWN: Have you had any panic attacks in the past month?

___ With panic attacks: if one or more panic attacks in the past month occurring in the context of current Specific Phobia (see page F.7) and criteria have never been met for Panic Disorder.
**PAST SPECIFIC PHOBIA**

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<td>Number of months prior to interview when last had a symptom of Specific Phobia</td>
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<td>SPECIFIC PHOBIA)?</td>
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<td>IF UNKNOWN: How old were you when you</td>
<td>Age at onset of Specific Phobia (CODE 99 IF UNKNOWN)</td>
<td>F110</td>
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<td>first started having (SXS OF SPECIFIC</td>
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<td>PHOBIA)?</td>
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? = Inadequate information  
1 = Absent or false  
2 = Subthreshold  
3 = Threshold or true
SCID-RV (for DSM-5®) (Version 1.0.0)  Current Generalized Anxiety Disorder  Anxiety Disorders  F.24

*CURRENT GENERALIZED ANXIETY DISORDER*

GENERALIZED ANXIETY DISORDER CRITERIA

IF SCREENING QUESTION #6 ANSWERED "NO," SKIP TO

*PAST GENERALIZED ANXIETY DISORDER*  F.27

IF QUESTION #6 ANSWERED "YES": You’ve said that over the last several months you’ve been feeling anxious and worried for a lot of the time. (Tell me about that.)

IF SCREENER NOT USED: Over the last several months, have you been feeling anxious and worried for a lot of the time? (Tell me about that.)

What kinds of things have you worried about? (What about your job, your health, your family members, your finances, or other smaller things like being late for appointments?) How much did you worry about (EVENTS OR ACTIVITIES)? What else have you worried about?

Have you worried about (EVENTS OR ACTIVITIES) even when there was no reason? (Have you worried more than most people would in your circumstances? Has anyone else thought you worried too much? Have you worried more than you should have given your actual circumstances?)

During the last 6 months, since (6 MONTHS AGO), would you say that you have been worrying more days than not?

When you’re worrying this way, have you found that it’s hard to stop yourself or to think about anything else?

Now I am going to ask you some questions about symptoms that often go along with being nervous or worried.

Thinking about those periods since (6 MONTHS AGO) when you have been feeling nervous, anxious, or worried...

...have you often felt physically restless, like you couldn’t sit still?

1. Restlessness or feeling keyed up or on edge.

...have you often felt keyed up or on edge?

2. Being easily fatigued.

...have you often tired easily?

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).

B. The person finds it difficult to control the worry.

C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms present for more days than not for the past 6 months):

1. Restlessness or feeling keyed up or on edge.
2. Being easily fatigued.
3. Difficulty concentrating, concentrating poorly, or mind going blank.
4. Difficulty making decisions, concentrating, or speaking.
5. Irritability.
6. Muscle tension or tenseness.

?=Inadequate information  1=Absent or false  2=Subthreshold  3=Threshold or true
...have you often had trouble concentrating or has your mind often gone blank?  
3. Difficulty concentrating or mind going blank.

...have you often been irritable?  
4. Irritability.

...have your muscles often been tense?  
5. Muscle tension.

...have you often had trouble falling or staying asleep?  How about often feeling tired when you woke up because you didn’t get a good night’s sleep?  
6. Sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep).

IF UNCLEAR: Did at least some of these symptoms like (SXS CODED “3”) happen for more days than not over the past 6 months?

AT LEAST THREE "C" SXS ARE CODED "3" AND AT LEAST SOME OCCURRED MORE DAYS THAN NOT FOR PAST 6 MONTHS

IF UNKNOWN: What effect have (GAD SXS) had on your life?

ASK THE FOLLOWING QUESTIONS AS NEEDED TO RATE CRITERION D:

How have (GAD SXS) affected your relationships or your interactions with other people? (Have [GAD SXS] caused you any problems in your relationships with your family, romantic partner or friends?)

How have (GAD SXS) affected your work/schoolwork? (How about your attendance at work or school? Have [GAD SXS] made it more difficult to do your work/schoolwork? How have [GAD SXS] affected the quality of your work/schoolwork?)

How have (GAD SXS) affected your ability to take care of things at home? How about doing other things that are important to you like religious activities, physical exercise, or hobbies? Have you avoided doing anything because you felt like you weren’t up to it?

Has your anxiety or worry affected any other important part of your life?

IF HAS NOT INTERFERED WITH LIFE: How much have you been bothered or upset by having (GAD SXS)?

?=Inadequate information  
1=Absent or false  
2=Subthreshold  
3=Threshold or true
SCID-RV (for DSM-5®) (Version 1.0.0)

Current Generalized Anxiety Disorder

E. [Primary Anxiety Disorder:] The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or to another medical condition.

IF THERE IS ANY INDICATION THAT THE ANXIETY MAY BE SECONDARY (I.E., A DIRECT PHYSIOLOGICAL CONSEQUENCE OF GMC OR SUBSTANCE/MEDICATION), GO TO *GMC/SUBSTANCE* F.33 AND RETURN HERE TO MAKE A RATING OF “1” OR “3.”

NOTE: Refer to list of etiological medical conditions and substances/medications on page F.4.

F. The disturbance is not better explained by another mental disorder (e.g., anxiety or worry about having a panic attacks in Panic Disorder, negative evaluation in Social Anxiety Disorder, contamination or other obsessions in Obsessive Compulsive Disorder, separation from attachment figures in Separation Anxiety Disorder, gaining weight in Anorexia Nervosa, physical complaints in Somatic Symptom disorder, perceived appearance flaws in Body Dysmorphic Disorder or having a serious illness in Illness Anxiety Disorder, or the content of delusional beliefs in Schizophrenia or Delusional Disorder).

GENERALIZED ANXIETY CRITERIA A, B, C, D, E, AND F ARE CODED “3.”

*AGE AT ONSET*

IF UNKNOWN: How old were you when you first started having (GAD SXS)?

Age at onset of Generalized Anxiety Disorder (CODE 99 IF UNKNOWN)

Specify if:

IF UNKNOWN: Have you had any panic attacks in the past month?

— With panic attacks: if one or more panic attacks in the past month occurring in the context of current Generalized Anxiety Disorder (see page F.7) and criteria have never been met for Panic Disorder

? = Inadequate information 1 = Absent or false 2 = Subthreshold 3 = Threshold or true
SCID-RV (for DSM-5®) (Version 1.0.0) Past Generalized Anxiety Disorder Anxiety Disorders F.27

**PAST GENERALIZED ANXIETY DISORDER**

**GENERALIZED ANXIETY DISORDER CRITERIA**

- **SCREEN Q#7 ANSWERED "NO," SKIP TO** *OTHER SPECIFIED ANXIETY DISORDER* F.31 **OR** *SEPARATION ANXIETY DISORDER* Opt-F.1

- **IF QUESTION #7 ANSWERED "YES":** You’ve said that you have had a time lasting at least several months in which you were feeling anxious and worried for a lot of the time? (Tell me about that.)

- **IF SCREENER NOT USED:** Have you ever had a time lasting at least several months in which you were feeling anxious and worried for a lot of the time? (Tell me about that time.)

What kinds of things did you worry about? (What about your job, your health, your family members, your finances, or other smaller things like being late for appointments?) How much did you worry about (EVENTS OR ACTIVITIES)? What else did you worry about?

Did you worry about (EVENTS OR ACTIVITIES) even when there was no reason? (Did you worry more than most people would in your circumstances? Did anyone else think you worried too much? Did you worry more than you should have given your actual circumstances?)

When was that? How long did it last? (At least 6 months?) During that time, were you worrying more days than not?

When you were worrying, did you find that it was hard to stop yourself?

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).

B. The person finds it difficult to control the worry.

?=Inadequate information 1=Absent or false 2=Subthreshold 3=Threshold or true
SCID-RV (for DSM-5®) (Version 1.0.0)

Past Generalized Anxiety Disorder

<table>
<thead>
<tr>
<th>C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms present for more days than not for the past 6 months):</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Restlessness or feeling keyed up or on edge.</td>
</tr>
<tr>
<td>2. Being easily fatigued.</td>
</tr>
<tr>
<td>3. Difficulty concentrating or mind going blank.</td>
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<tr>
<td>4. Irritability.</td>
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<tr>
<td>5. Muscle tension.</td>
</tr>
<tr>
<td>6. Sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep).</td>
</tr>
</tbody>
</table>

IF UNCLEAR: Did at least some of these symptoms like (SXS CODED "3") happen for more days than not over the (6 MONTH PERIOD OF ANXIETY AND WORRY)?

AT LEAST THREE "C" SXS ARE CODED "3."

<table>
<thead>
<tr>
<th>1=Absent or false</th>
<th>2=Subthreshold</th>
<th>3=Threshold or true</th>
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</table>

GO TO *OTHER SPECIFIED ANXIETY DISORDER* F.31 OR *SEPARATION ANXIETY DISORDER* Opt-F.1

?=Inadequate information
IF UNKNOWN: What effect did (GAD SXS) have on your life?

ASK THE FOLLOWING QUESTIONS AS NEEDED TO RATE CRITERION D:

How did (GAD SXS) affect your relationships or your interactions with other people? (Did [GAD SXS] cause you any problems in your relationships with your family, romantic partner or friends?)

How did (GAD SXS) affect your school/work? (How about your attendance at work or school? Did [GAD SXS] make it more difficult to do your work/schoolwork? How did [GAD SXS] affect the quality of your work/schoolwork?)

How did (GAD SXS) affect your ability to take care of things at home? How about doing other things that are important to you like religious activities, physical exercise, or hobbies? Did you avoid doing anything because you felt like you weren’t up to it?

Did your anxiety or worry affect any other important part of your life?

IF HAS NOT INTERFERED WITH LIFE: How much were you bothered or upset by having (GAD SXS)?

D. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
SCID-RV (for DSM-5®) (Version 1.0.0)

Past Generalized Anxiety Disorder

Anxiety Disorders F.30

IF UNKNOWN: When did (GAD SXS) begin?

Just before you began having (GAD SXS), were you taking any drugs, caffeine, diet pills, or other medicines?

(How much coffee, tea, or caffeinated soda did you drink a day?)

Just before (GAD SXS) began, were you physically ill?

IF YES: What did the doctor say?

IF NECESSARY, RETURN TO THIS ITEM AFTER COMPLETING MODULE FOR OC AND RELATED DISORDERS, EATING DISORDERS, AND SOMATIC SYMPTOM DISORDERS.

E. [Primary Anxiety Disorder:] The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or to another medical condition.

IF THERE IS ANY INDICATION THAT THE ANXIETY MAY BE SECONDARY (I.E., A DIRECT PHYSIOLOGICAL CONSEQUENCE OF GMC OR SUBSTANCE/MEDICATION), GO TO *GMC/SUBSTANCE* F.33 AND RETURN HERE TO MAKE A RATING OF "1" OR "3."

NOTE: Refer to list of etiological medical conditions and substances/medications on page F.4.

F. The disturbance is not better explained by another mental disorder (e.g., anxiety or worry about having a panic attacks in Panic Disorder, negative evaluation in Social Anxiety Disorder, contamination or other obsessions in Obsessive Compulsive Disorder, separation from attachment figures in Separation Anxiety Disorder, gaining weight in Anorexia Nervosa, physical complaints in Somatic Symptom Disorder, perceived appearance flaws in Body Dysmorphic Disorder or having a serious illness in Illness Anxiety Disorder, or the content of delusional beliefs in Schizophrenia or Delusional Disorder).

GENERALIZED ANXIETY CRITERIA A, B, C, D, E, AND F ARE CODED "3."

*AGE AT ONSET*

IF UNKNOWN: How old were you when you first started having (GAD SXS)?

Age at onset of Generalized Anxiety Disorder (CODE 99 IF UNKNOWN) _____ _____

?=Inadequate information 1=Absent or false 2=Subthreshold 3=Threshold or true 152
*OTHER SPECIFIED ANXIETY DISORDER*

NOTE: IF ANXIETY SYMPTOMS ARE CURRENT AND ARE TEMPORALLY ASSOCIATED WITH A PSYCHOSOCIAL STRESSOR, CONSIDER ADJUSTMENT DISORDER, PAGE L.20

IF UNKNOWN: What effect did (ANXIETY SXS) have on your life?

ASK THE FOLLOWING QUESTIONS AS NEEDED TO RATE CRITERION:

How have (ANXIETY SXS) affected your relationships or your interactions with other people? (Have [ANXIETY SXS] caused you any problems in your relationships with your family, romantic partner or friends?)

How have (ANXIETY SXS) affected your school/work? (How about your attendance at work or school? Have [ANXIETY SXS] made it more difficult to do your work/schoolwork? How have [ANXIETY SXS] affected the quality of your work/schoolwork?)

How have (ANXIETY SXS) affected your ability to take care of things at home? How about doing other things that are important to you like religious activities, physical exercise, or hobbies? Have you avoided doing anything because you felt like you weren’t up to it?

Have your anxiety or worry affected any other important part of your life?

IF HAS NOT INTERFERED WITH LIFE: How much were you bothered or upset by having (ANXIETY SXS)?

OTHER SPECIFIED ANXIETY DISORDER CRITERIA

Symptoms characteristic of an anxiety disorder...predominate...but do not meet full criteria for any of the disorders in the Anxiety Disorders diagnostic class [or for Adjustment Disorder with Anxiety or Adjustment Disorder with Mixed Anxiety and Depression].

[Symptoms] cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

? = Inadequate information 1 = Absent or false 2 = Subthreshold 3 = Threshold or true
**SCID-RV (for DSM-5®) (Version 1.0.0)**

**Other Specified Anxiety Disorder**

**Anxiety Disorders** F.32

**Just before you began having (ANXIETY SXS) were you taking any drugs, stimulants or medicines?**

(How much coffee, tea, or caffeinated beverages do you drink a day?)

**Just before (ANXIETY SXS) began, were you physically ill? (What did the doctor say?)**

[Primary Other Specified Anxiety Disorder:] Not due to the direct physiological effects of a substance (e.g., a drug of abuse), medication or to another medical condition.

IF THERE IS ANY INDICATION THAT THE ANXIETY MAY BE SECONDARY (I.E., A DIRECT PHYSIOLOGICAL CONSEQUENCE OF GMC OR SUBSTANCE/MEDICATION), GO TO "GMC/SUBSTANCE" F.33 AND RETURN HERE TO MAKE A RATING OF "1" OR "3."

NOTE: Refer to list of etiological medical conditions and substances/medications on page F.4.

**IF UNCLEAR: During the past month, have you had (ANXIETY SXS)?**

Check here____ if current in the past month.

*Indicate type of Other Specified Anxiety Disorder: (circle the appropriate number)*

1 - **Limited-symptom panic attacks**

2 - **Generalized anxiety not occurring more days than not**

3 - Situations in which the clinician has concluded that an Anxiety Disorder is present but is **unable to determine whether it is primary or secondary** (i.e., due to another medical condition or is substance/medication-induced).

4 - **Other:** ________________________________

5 - **Unspecified:** There is insufficient information to make a more specific diagnosis.

GO TO NEXT MODULE
*GMC/SUBSTANCE AS ETIOLOGY FOR ANXIETY SYMPTOMS*

*ANXIETY DISORDER DUE TO ANOTHER MEDICAL CONDITION*  ANXIETY DISORDER DUE TO ANOTHER MEDICAL CONDITION CRITERIA

IF SYMPTOMS NOT TEMPORALLY ASSOCIATED WITH A GENERAL CONDITION CHECK HERE ___ AND GO TO *SUBSTANCE/MEDICATION-INDUCED ANXIETY DISORDER* F.35

CODE BASED ON INFORMATION ALREADY OBTAINED

A. Panic attacks or anxiety is predominant in the clinical picture.  

B/C. There is evidence from this history, physical examination, or laboratory findings that the disturbance is the direct physiological consequence of another medical condition AND the disturbance is not better accounted for by another mental disorder.

Did the (ANXIETY SXS) start or get much worse only after (GMC) began? How long after (GMC) began did (ANXIETY SXS) start or get much worse?  

NOTE: The following factors should be considered and, if present, support the conclusion that a general medical condition is etiologic to the anxiety symptoms.

1) There is evidence from the literature of a well-established association between the general medical condition and the anxiety symptoms. (Refer to list of etiological general medical conditions on page F.4.)

2) There is a close temporal relationship between the course of the anxiety symptoms and the course of the general medical condition.

3) The anxiety symptoms are characterized by unusual presenting features (e.g., late age-at-onset).

4) The absence of alternative explanations (e.g., anxiety symptoms as a psychological reaction to the stress of being diagnosed with a general medical condition).

1 = Absent or false  
2 = Subthreshold  
3 = Threshold or true  

? = Inadequate information
E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

NOTE: The D criterion (delirium rule-out) has been omitted.
**SUBSTANCE/MEDICATION-INDUCED ANXIETY DISORDER**

**SUBSTANCE/MEDICATION-INDUCED ANXIETY DISORDER CRITERIA**

*If symptoms not temporally associated with substance/medication use, check here ___ and return to disorder being evaluated, continuing with the item following "symptoms are not attributable to the physiological effects of a substance or another medical condition" (see page numbers in box to the right).*

**CODE BASED ON INFORMATION ALREADY OBTAINED**

A. Panic attacks or anxiety is predominant in the clinical picture.

B. There is evidence from the history, physical examination, or laboratory findings of both (1) and (2):

1. The symptoms in criterion A developed during or soon after substance intoxication or withdrawal or exposure to a medication.

2. The involved substance/medication is capable of producing the symptoms in Criterion A.

C. The disturbance is NOT better accounted for by an anxiety disorder that is not substance-induced. Such evidence of an independent anxiety disorder could include the following:

   1) The symptoms precede the onset of the substance/medication use;

   2) The symptoms persist for a substantial period of time (e.g., about 1 month) after the cessation of acute withdrawal or severe intoxication; or

   3) There is other evidence suggesting the existence of an independent non-substance/medication-induced anxiety disorder (e.g., a history of recurrent non-substance/medication-related episodes).

**ASK ANY OF THE FOLLOWING QUESTIONS AS NEEDED TO RULE OUT A NON-SUBSTANCE-INDUCED ETIOLOGY:**

IF UNKNOWN: Which came first, the (substance/medication use) or the (anxiety sx)?

IF UNKNOWN: Have you had a period of time when you stopped using (substance/medication)?

   IF YES: After you stopped using (substance/medication) did the (anxiety sx) go away or get better?

   IF YES: How long did it take for them to get better? Did they go away within a month of stopping?

IF UNKNOWN: Have you had any other episodes of (anxiety sx)?

   IF YES: How many? Were you using (substance/medication) at those times?

**EPISODE BEING EVALUATED:**

- Panic F.4
- Social Anxiety Disorder F.16
- Current GAD F.26
- Past GAD F.30
- Other Specified Anxiety F.32

?=Inadequate information  1=Absent or false  2=Subthreshold  3=Threshold or true
IF UNKNOWN: What effect did (ANXIETY SXS) have on your life?

ASK THE FOLLOWING QUESTIONS AS NEEDED TO RATE CRITERION E:

How did (ANXIETY SXS) affect your relationships or your interactions with other people? (Did [ANXIETY SXS] cause you any problems in your relationships with your family, romantic partner or friends?)

How did (ANXIETY SXS) affect your work/schoolwork? (How about your attendance at work or school? Did [ANXIETY SXS] make it more difficult to do your work/schoolwork? How did [ANXIETY SXS] affect the quality of your work/schoolwork?)

How did (ANXIETY SXS) affect your ability to take care of things at home? How about doing other things that are important to you like religious activities, physical exercise, or hobbies? Did you avoid doing anything because you felt like you weren’t up to it?

Did your anxiety or worry affect any other important part of your life?

IF HAS NOT INTERFERED WITH LIFE: How much were you bothered or upset by having (ANXIETY SXS)?

SUBSTANCE-INDUCED ANXIETY DISORDER CRITERIA A, B, C, AND E ARE CODED “3.”

Check here____ if current in the past month.

Indicate context of development of anxiety symptoms:
1 – With onset during intoxication
2 – With onset during withdrawal
3 – With onset after medication use

Specify if:
   ___ With panic attacks (Refer to page F.7)

RETURN TO EPISODE BEING EVALUATED

?=Inadequate information        1=Absent or false        2=Subthreshold        3=Threshold or true
0G. OBSESSIVE-COMPULSIVE AND RELATED DISORDERS

*OBSESSIVE-COMPULSIVE DISORDER*

**OBSESSIVE-COMPULSIVE DISORDER CRITERIA**

**SCREEN Q#8**

**SCREEN Q#9**

**SCREEN Q#10**

IF SCREENER NOT USED: 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? (What were they?)

How about having images pop into your head that you didn’t want like violent or horrible scenes or something of a sexual nature? (What were they?)

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? (What were they?)

IF YES TO ANY OF ABOVE: Have these (THOUGHTS/IMAGES/URGES) made you very anxious or upset?

When you had these (THOUGHTS/IMAGES/URGES) did you try hard to get them out of your head? (What would you try to do?)

A. Presence of obsessions, compulsions, or both:

Obsessions are defined by (1) and (2):

1. Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress.

2. The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion).

DESCRIBE CONTENT OF OBSESSION(S):
**COMPULSIONS**

*IF SCREENING QUESTION #11 ANSWERED "NO," GO TO *SKIP OUT IF NEITHER OBSESSIONS NOR COMPULSIONS* G.3 (NOTE: BECAUSE SOME SUBJECTS WITH OCD MAY BE RELUCTANT TO CONFIDE THEIR COMPULSIONS DURING THE SCREENING, CONSIDER RE-ASKING SCREENING QUESTION BELOW AT THIS POINT IN THE SCID.)*

*IF QUESTION #11 ANSWERED "YES": You’ve said that there were things you had to do over and over again and were hard to resist doing, like washing your hands again and again, repeating something over and over again until it “felt right,” counting up to a certain number, or checking something many times to make sure that you’d done it right. Tell me about that.

*IF SCREENER NOT USED: Was there ever anything that you had to do over and over again and was hard to resist doing, like washing your hands again and again, repeating something over and over again until it “felt right,” counting up to a certain number, or checking something many times to make sure that you’d done it right?*

Tell me about that. (What did you have to do?)

*IF UNCLEAR: Why did you have to do (COMPULSIVE ACT)? What would happen if you didn’t do it?*

*IF UNCLEAR: How many times would you do (COMPULSIVE ACT)? Have you been doing (COMPULSIVE ACT) more than really made sense?*

1. Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession, or according to rules that must be applied rigidly.

2. The behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however these 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.

GO TO *SKIP OUT IF NEITHER OBSESSIONS NOR COMPULSIONS* G.3 (TOP OF NEXT PAGE)

DESCRIBE CONTENT OF COMPULSION(S):

?=inadequate information  1=absent or false  2=subthreshold  3=threshold or true
SCID-RV (for DSM-5®) (Version 1.0.0)  Obsessive-Compulsive  OC and Related Disorders  G.3

*SKIP OUT IF NEITHER OBSESSIONS NOR COMPULSIONS*

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

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

IF UNKNOWN: How much time do you spend on (OBSESSION OR COMPULSION)?

IF UNKNOWN: What effect did these (OBSESSIONS OR COMPULSIONS) have on your life?

ASK THE FOLLOWING QUESTIONS AS NEEDED TO RATE CRITERION B:

How have (OBSESSIONS OR COMPULSIONS) affected your relationships or your interactions with other people? (Have they caused you any problems in your relationships with your family, romantic partner, roommates or friends?)

How have (OBSESSIONS OR COMPULSIONS) affected your work/school? (How about your attendance at work or school? Have [OBSESSIONS OR COMPULSIONS] made it more difficult to do your work/schoolwork)? How have (OBSESSIONS OR COMPULSIONS) affected the quality of your work/schoolwork?)

How have (OBSESSIONS OR COMPULSIONS) affected your ability to take care of things at home? How about doing other things that are important to you like religious activities, physical exercise, or hobbies?

Have (OBSESSIONS OR COMPULSIONS) affected any other important part of your life?

IF HAVE NOT INTERFERED WITH LIFE: How much have you been bothered by having (OBSESSIONS OR COMPULSIONS)?

B. The obsessions or compulsions are time consuming (e.g., take more than 1 hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

? 1 2 3 G10

GO TO *OTHER SPECIFIED OC AND RELATED DISORDER* G.8, OR GO TO *HOARDING DISORDER (OPTIONAL)* Opt-G.1

? = inadequate information  1 = absent or false  2 = subthreshold  3 = threshold or true
If Unknown: When did (Obsessions or Compulsions) begin?

Just before this began, were you physically ill?
If yes: What did the doctor say?

Just before this began, were you using any medications?
If yes: Any change in the amount you were using?

Just before this began, were you drinking or using any drugs?

If Necessary, return to this item after completing modules for optional OC and related disorders, somatic symptom disorders, and trauma- and stress-related disorders.

C. [Primary Obsessive-Compulsive Disorder.]
The obsessive-compulsive symptoms are not attributable to the physiological effects of a substance/medication or to another medical condition.

If there is any indication that the obsessions or compulsions may be secondary (i.e., a direct physiological consequence of a GMC or substance), go to *GMC/Substance* G.11 and return here to make a rating of “1” or “3.”

Etiological medical conditions include:
Sydenham’s chorea, medical conditions leading to striatal damage, such as cerebral infarction.

Etiological substances/medications include:
Intoxication with cocaine, amphetamines or other stimulants and exposure to heavy metals.

D. The disturbance is not better explained by the symptoms of another mental disorder (e.g., excessive worries, as in Generalized Anxiety Disorder; preoccupation with appearance, as in Body Dysmorphic Disorder; difficulty discarding or parting with possessions, as in Hoarding Disorder; hair pulling, as in Trichotillomania; skin picking, as in Excoriatio Disorder; stereotypies, as in Stereotypic Movement Disorder; ritualized eating behavior, as in Eating Disorders; preoccupation with substances or gambling, as in Substance-Related and Addictive Disorders; preoccupation with having an illness, as in Illness Anxiety Disorder; sexual urges or fantasies, as in Paraphilic Disorders; impulses, as in Disruptive, Impulse-Control, and Conduct Disorders; guilty ruminations, as in Major Depressive Disorder; thought insertion or delusional preoccupations, as in Schizophrenia Spectrum and Other Psychotic Disorders; or repetitive patterns of behavior, as in Autism Spectrum Disorder).

G.8, or go to *Hoarding Disorder (Optional)* Opt-G.1

G.11

Due to substance use or a GMC, go to *Other Specified OC and Related Disorder* G.8, or go to *Hoarding Disorder (Optional)* Opt-G.1

Continue with next item
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**OBSESSIVE COMPULSIVE DISORDER CRITERIA A, B, C, D, AND E ARE CODED “3.”**

1 3 G13

**GO TO **

*PAST OCD*  

G.7

****OCD CHRONOLOGY**

**NOTE:** IF LIFETIME ASSESSMENT HAS ALREADY DETERMINED THE PRESENCE OF OBSESSIONS AND/OR COMPULSIONS DURING THE PAST MONTH, ASK THE FOLLOWING QUESTIONS ONLY IF NEEDED.

**Since (1 MONTH AGO), have you had any** (OBSESSIONS OR COMPULSIONS MENTIONED ABOVE)?

**Since (1 MONTH AGO), how much time have you spent on** (OBSESSIONS OR COMPULSIONS)?

**IF UNKNOWN:** During the past month, since (1 MONTH AGO), what effect have (OBSESSIONS OR COMPULSIONS) had on your life?

**IF DID NOT INTERFERE WITH LIFE:** During the past month, since (1 MONTH AGO), how much have you been bothered by having (OBSESSIONS OR COMPULSIONS)?

? 1 3 G14

**GO TO **

*PAST OCD*  

G.7

? 1 3 G15

**GO TO **

*OTHER SPECIFIED OC AND RELATED DISORDER*  

G.8, OR GO TO  

*HOarding DISORDER (OPTIONAL)*  

Opt-G.1

**OBSESSIVE-COMPULSIVE DISORDER; CONTINUE BELOW.**
*CURRENT OCD*

CRITERIA A AND B CODED "3" FOR PAST MONTH

**IF UNKNOWN:** How old were you when you first started having (OCD SXS)?

Age at onset of Obsessive Compulsive Disorder (CODE 99 IF UNKNOWN)  

**IF MORE THAN ONE OCD BELIEF INVOLVING A FEARED CONSEQUENCE:** Which belief about something terrible that could happen to you or someone else is the most upsetting to you? (Like if you don’t check the stove over and over the house will burn down, or if you touch an ashtray you’ll get cancer, or if you felt a bump in the road while you were driving you believed you really did run over someone.)

Specify current level of insight (i.e., during the past week): (circle the appropriate number)

1 - With good or fair insight: The individual recognizes that Obsessive-Compulsive Disorder beliefs are definitely or probably not true or that they may or may not be true.

2 - With poor insight: The individual thinks Obsessive-Compulsive Disorder beliefs are probably true.

3 - With absent insight/delusional beliefs: The individual is completely convinced that Obsessive-Compulsive Disorder beliefs are true.

4 - Not applicable. OCD symptoms are not associated with a feared consequence that involves a belief.

Specify if:

**IF UNKNOWN:** Has there ever been a time when you had tics, where you were repeatedly making sounds or movements that were difficult to control?

Tic-related: The individual has a current or past history of a Tic Disorder (i.e., a disturbance characterized by sudden, rapid, recurrent, nonrhythmic motor movements or vocalizations) [typically based on clinician judgment of a current or past diagnosis of Tic Disorder]

Specify if:

**IF UNKNOWN:** Have you had any panic attacks in the past month?

With panic attacks: If one or more panic attacks in the past month occurring in the context of current Obsessive Compulsive Disorder (see page F.7) and criteria have never been met for Panic Disorder.

GO TO *OTHER SPECIFIED OC AND RELATED DISORDER* G.8, OR GO TO *HOARDING DISORDER (OPTIONAL)* Opt-G.1

?=inadequate information  1=absent or false  2=subthreshold  3=threshold or true
*PAST OCD*

When did you last have (ANY OCD SXS)?

Number of months prior to interview when last had a symptom of Obsessive Compulsive Disorder

IF UNKNOWN: How old were you when you first started having (OCD SXS)?

Age at onset of Obsessive Compulsive Disorder (CODE 99 IF UNKNOWN)

GO TO *OTHER SPECIFIED OC AND RELATED DISORDER* G.8, OR GO TO *HOARDING DISORDER (OPTIONAL)* Opt-G.1

? = inadequate information  
1 = absent or false  
2 = subthreshold  
3 = threshold or true
*OTHER SPECIFIED OBSESSIVE-COMPULSIVE AND RELATED DISORDER*

IF UNKNOWN: What effect did have (OC-RELATED SXS) had on your life?

ASK THE FOLLOWING QUESTIONS AS NEEDED TO RATE CRITERION:

- How have (OC-RELATED SXS) affected your relationships or your interactions with other people? (Have they caused you any problems in your relationships with your family, romantic partner or friends?)

- How have (OC-RELATED SXS) affected your work/school? (How about your attendance at work or school? Have [OC-RELATED SXS] made it more difficult to do your work/schoolwork? How did [OC-RELATED SXS] affect the quality of your work/schoolwork?)

- How have (OC-RELATED SXS) affected your ability to take care of things at home? What about being involved in things that are important to you, like religious activities, physical exercise, or hobbies? Have you avoided situations or people because you didn't want other people to see you doing (OC-RELATED BEHAVIORS)?

- Have (OC-RELATED SXS) affected any other important part of your life?

IF HAVE NOT INTERFERED WITH LIFE: How much has your (OC-RELATED SXS) bothered or upset you?

OTHER SPECIFIED OBSESSIVE-COMPULSIVE AND RELATED DISORDER CRITERIA

A presentation in which symptoms characteristic of an Obsessive-Compulsive and Related Disorder predominate but do not meet the full criteria for any of the disorders in the obsessive-compulsive and related disorders diagnostic class.

[Symptoms] cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate.

1 3 G23

GO TO NEXT MODULE

1 2 3 G24

GO TO NEXT MODULE

?=inadequate information 1=absent or false 2=subthreshold 3=threshold or true
IF UNKNOWN: When did (OC-RELATED SXS) begin?

Just before (OC-RELATED SXS) began, were you physically ill?
   IF YES: What did the doctor say?

Just before (OC-RELATED SXS) began, were you using any medications?
   IF YES: Any change in the amount you were using?

Just before (OC-RELATED SXS) began, were you drinking or using any drugs?

IF UNCLEAR: During the past month, since (1 MONTH AGO), have you had (OC-RELATED SXS)?

[Primary Other OC and Related Disorder: Not due to the direct physiological effects of a substance/medication or to another medical condition.]

IF THERE IS ANY INDICATION THAT THE OC-RELATED SYMPTOMS MAY BE SECONDARY (I.E., A DIRECT PHYSIOLOGICAL CONSEQUENCE OF GMC OR SUBSTANCE), GO TO *GMC/SUBSTANCE* G.11 AND RETURN HERE TO MAKE A RATING OF "1" OR "3."

NOTE: Refer to list of etiological medical conditions and substances/medications on page G.4.

Check here ___ if present in past month.

CONTINUE WITH TYPE ON NEXT PAGE
Indicate type of other specified OC and Related Disorder: (circle the appropriate number)

1 - **Body dysmorphic–like disorder with actual flaws**: This is similar to Body Dysmorphic Disorder except that the defects or flaws in physical appearance are clearly observable by others (i.e., they are more noticeable than “slight”). In such cases, the preoccupation with these flaws is clearly excessive and causes significant impairment or distress.

2 - **Body dysmorphic–like disorder without repetitive behaviors**: Presentations that meet Body Dysmorphic Disorder except that the individual has not performed repetitive behaviors or mental acts in response to the appearance concerns.

3 - **Body-focused repetitive behavior disorder**: This is characterized by recurrent body-focused repetitive behaviors (e.g., nail biting, lip biting, cheek chewing) and repeated attempts to decrease or stop the behaviors. These symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning and are not better explained by Trichotillomania (hair-pulling disorder), Excoriation (skin-picking) Disorder, or Stereotypic Movement Disorder.

4 - **Obsessional jealousy**: This is characterized by nondelusional preoccupation with a partner’s perceived infidelity. The preoccupations may lead to repetitive behaviors or mental acts in response to the infidelity concerns; they cause clinically significant distress or impairment in social, occupational, or other important areas of functioning; and they are not better explained by another mental disorder such as Delusional Disorder, Jealous Type, or Paranoid Personality Disorder.

5 - Situations in which the clinician has concluded that an Obsessive-Compulsive and Related Disorder is present but is unable to determine whether it is primary or secondary (i.e., due to another medical condition or is substance/medication-induced).

6 - Other: ___________________ ___________________

7 - **Unspecified**: There is insufficient information to make a more specific diagnosis
**GMC/SUBSTANCE CAUSING OBSESSIVE-COMPULSIVE AND RELATED SYMPTOMS**

**OBSESSIVE-COMPULSIVE AND RELATED DISORDER DUE TO ANOTHER MEDICAL CONDITION**

*IF SYMPTOMS NOT TEMPORALLY ASSOCIATED WITH A GENERAL MEDICAL CONDITION, CHECK HERE ___ AND GO TO *SUBSTANCE-INDUCED OC AND RELATED DISORDER* G.14.

**CODE BASED ON INFORMATION ALREADY OBTAINED**

A. Obsessions, compulsions, preoccupations with appearance, hoarding, skin picking, hair pulling, other body-focused repetitive behaviors, or other symptoms characteristic of obsessive-compulsive and related disorder predominate in the clinical picture.

B/C. There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct physiological consequence of another medical condition AND the disturbance is not better accounted for by another mental disorder.

**Did (OC AND RELATED SXS) start or get much worse only after (GMC) began?**

**How long after (GMC) began did (OC AND RELATED SXS) start or get much worse?**

**IF GMC HAS RESOLVED: Did the (OC AND RELATED SYMPTOMS) get better once the (GMC) got better?**

NOTE: The following factors should be considered and, if present, support the conclusion that a general medical condition is etiologic to the obsessive-compulsive and related symptoms.

1) There is evidence from the literature of a well-established association between the general medical condition and the obsessive-compulsive and related symptoms. (Refer to list of etiological general medical conditions on page G.4.)

2) There is a close temporal relationship between the course of the obsessive-compulsive and related symptoms and the course of the general medical condition.

3) The obsessive-compulsive and related symptoms are characterized by unusual presenting features (e.g., late age-at-onset).

4) The absence of alternative explanations (e.g., obsessive-compulsive and related symptoms as a psychological reaction to the stress of being diagnosed with a general medical condition).

?=inadequate information 1=absent or false 2=subthreshold 3=threshold or true
SCID-RV (for DSM-5®) (Version 1.0.0)  OC Disorder Due to AMC  OC and Related Disorders  G.12

IF UNKNOWN:  What effect have (OC-RELATED SXS) had on your life?

ASK THE FOLLOWING QUESTIONS AS NEEDED TO RATE CRITERION E.:

How have (OC-RELATED SXS) affected your relationships or your interactions with other people?  (Have they caused you any problems in your relationships with your family, romantic partner or friends?)

How have (OC-RELATED SXS) affected your work/school?  (How about your attendance at work or school?  Have [OC-RELATED SXS] made it more difficult to do your work/schoolwork)?  How have [OC-RELATED SXS] affected the quality of your work/schoolwork?)

How have (OC-RELATED SXS) affected your ability to take care of things at home?  What about being involved in things that are important to you, like religious activities, physical exercise, or hobbies?  Have you avoided situations or people because you didn’t want other people to see you doing (OC-RELATED BEHAVIORS)?

Have (OC-RELATED SXS) affected any other important part of your life?

IF HAVE NOT INTERFERED WITH LIFE:  How much have your (OC-RELATED SXS) bothered or upset you?

E.  The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning

NOTE: The D criterion (delirium rule-out) has been omitted.

?=inadequate information  1=absent or false  2=subthreshold  3=threshold or true
OC AND RELATED DISORDER DUE TO AMC

CRITERIA A, B/C, AND E CODED “3.”

Check here __ if current in the past month.

Specify if:


2 - With appearance preoccupations: If preoccupation with perceived appearance defects or flaws predominate in the clinical presentation.

3 - With hoarding symptoms: If hoarding predominates in the clinical presentation.

4 - With hair-pulling symptoms: If hair pulling predominates in the clinical presentation.

5 - With skin-picking symptoms: If skin picking predominates in the clinical presentation.
*SUBSTANCE-/MEDICATION-INDUCED OC AND RELATED DISORDER*

IF SYMPTOMS NOT TEMPORALLY ASSOCIATED WITH SUBSTANCE/MEDICATION USE (OR IF SYMPTOMS CONFINED TO HOARDING), CHECK HERE ____ AND RETURN TO EPISODE BEING EVALUATED, CONTINUING WITH THE ITEM FOLLOWING "SYMPTOMS ARE NOT ATTRIBUTABLE TO THE PHYSIOLOGICAL EFFECTS OF A SUBSTANCE OR ANOTHER MEDICAL CONDITION" (SEE PAGE NUMBERS IN BOX TO THE RIGHT).

CODE BASED ON INFORMATION ALREADY OBTAINED.

IF NOT KNOWN:  When did the (OC AND RELATED SXS) begin?  Were you already using (SUBSTANCE/MEDICATION) or had you just stopped or cut down your use?

IF UNKNOWN:  How much (SUBSTANCE/MEDICATION) were you using when you began to have (OC AND RELATED SXS)?

ASK ANY OF THE FOLLOWING QUESTIONS AS NEEDED TO RULE OUT A NON-SUBSTANCE-INDUCED ETIOLOGY.

IF UNKNOWN:  Which came first, the (SUBSTANCE/MEDICATION USE) or the (OC AND RELATED SXS)?

IF UNKNOWN:  Have you had a period of time when you stopped using (SUBSTANCE/MEDICATION)?

IF YES:  After you stopped using (SUBSTANCE/MEDICATION) did the (OC AND RELATED SXS) go away or get better?

IF YES:  How long did it take for them to get better?  Did they go away within a month of stopping?

IF UNKNOWN:  Have you had any other episodes of (OC AND RELATED SXS)?

IF YES:  How many?  Were you using (SUBSTANCE/MEDICATION) at those times?

A. Obsessions, compulsions, skin picking, hair pulling, other body-focused repetitive behaviors, or other symptoms characteristic of the obsessive-compulsive and related disorders predominate in the clinical picture.

B. There is evidence from the history, physical examination, or laboratory findings of both (1) and (2):

1. The symptoms in criterion A developed during or soon after substance intoxication or withdrawal or exposure to a medication

2. The involved substance/medication is capable of producing the symptoms in Criterion A

NOTE: Refer to list of etiological substances/medications on page G.4.

C. The disturbance is NOT better accounted for by an obsessive-compulsive and related disorder that is not substance-induced. Such evidence of an independent obsessive-compulsive disorder and related disorder could include the following:

NOTE: The following three statements constitute evidence that the anxiety symptoms are not substance-induced. Code "1" if any are true. Code "3" only if none are true.

The symptoms precede the onset of the substance/medication use;

The symptoms persist for a substantial period of time (e.g., about 1 month) after the cessation of acute withdrawal or severe intoxication;

There is other evidence suggesting the existence of an independent non-substance/medication-induced obsessive-compulsive and related disorder (e.g., a history of recurrent non-substance/medication-related episodes).
SCID-RV (for DSM-5®) (Version 1.0.0) Substance-Induced OCD OC and Related Disorders G.15

**IF UNKNOWN:** What effect have (OC-RELATED SXS) had on your life?

**ASK THE FOLLOWING QUESTIONS AS NEEDED TO RATE CRITERION E:**

How have (OC-RELATED SXS) affected your relationships or your interactions with other people? (Have they caused you any problems in your relationships with your family, romantic partner or friends?)

How have (OC-RELATED SXS) affected your work/school? (How about your attendance at work or school? Have [OC-RELATED SXS] made it more difficult to do your work/schoolwork)? How have [OC-RELATED SXS] affected the quality of your work/schoolwork?)

How have (OC-RELATED SXS) affected your ability to take care of things at home? What about being involved in things that are important to you like religious activities, physical exercise, or hobbies? Have you avoided situations or people because you didn't want other people to see you doing (OC-RELATED BEHAVIOR)?

Have (OC-RELATED SXS) affected any other important part of your life?

**IF HAVE NOT INTERFERED WITH LIFE:** How much have your (OC-RELATED SXS) bothered or upset you?

E. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

**NOTE:** The D criterion (delirium rule-out) has been omitted.

?=inadequate information 1=absent or false 2=subthreshold 3=threshold or true

RETURN TO EPISODE BEING EVALUATED
SUBSTANCE/MEDICATION-INDUCED OBSESSIVE-COMPULSIVE AND RELATED DISORDER CRITERIA A, B, C, AND E ARE CODED “3.”

Check here ___ if current in past month.

Specify if:

1 - **With onset during intoxication:**
   If the criteria are met for intoxication with the substance and the symptoms develop during intoxication.

2 - **With onset during withdrawal:**
   If criteria are met for withdrawal from the substance and the symptoms develop during, or shortly after, withdrawal.

3 - **With onset after medication use:**
   Symptoms may appear either at initiation of medication or after a modification or change in use.

RETURN TO EPISODE BEING EVALUATED
I. FEEDING AND EATING DISORDERS

*ANOREXIA NERVOSA*

IF SCREENING QUESTION #12 ANSWERED "NO," CHECK HERE ___ AND SKIP TO

*BULIMIA NERVOSA* 1.4

IF QUESTION #12 ANSWERED "YES":

You've said that there was a time when you weighed much less than other people thought you ought to weigh.

IF SCREENER NOT USED: Now I would like to ask you some questions about your eating habits and your weight. Have you ever had a time when you weighed much less than other people thought you ought to weigh?

IF YES: Why was that? How much did you weigh? How old were you then? How tall were you?

IF LIFETIME RATING OF "3": During the past 3 months, since (3 MONTHS AGO), what is the lowest your weight has been?

At that time, were you very afraid that you could become fat?

IF NO: Tell me about your eating habits. (Have you avoided high calorie foods or high fat foods? How strict are you about it? Have you ever thrown up after you eaten? How often? Do you exercise a lot after you eat?)

IF LIFETIME RATING OF "3": Has this also been the case during the past 3 months, since (3 MONTHS AGO)?

At your lowest weight, did you still feel too fat or that part of your body was too fat?

IF NO: Did you need to be very thin in order to feel better about yourself?

IF NO AND LOW WEIGHT IS MEDICALLY SERIOUS: When you were that thin, did anybody tell you it could be dangerous to your health to be that thin? (What did you think?)

IF LIFETIME RATING OF "3": Has this also been the case in the past 3 months, since (3 MONTHS AGO)?

ANOREXIA NERVOSA CRITERIA A, B, AND C ARE CODED "3"

A. Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than minimally normal or, for children and adolescents, less than minimally expected.

B. Intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain, even though underweight.

C. Disturbance in the way in which one's body weight or shape is experienced; undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

?=inadequate information  1=absent or false  2=subthreshold  3=threshold or true
*ANOREXIA NERVOSA CHRONOLOGY*

ANOREXIA NERVOSA CRITERIA A, B, AND C ARE CODED "3" FOR THE PAST 3 MONTHS

? 1 3

PAST CURRENT
ANOREXIA ANOREXIA
NERVOSA NERVOSA

Indicate current severity by circling the appropriate number. (The level of severity may be increased to reflect clinical symptoms, the degree of functional disability, and the need for supervision.)

1 - Mild: BMI ≥ 17 kg/m²
2 - Moderate: BMI 16-16.99 kg/m²
3 - Severe: BMI 15-15.99 kg/m²
4 - Extreme: BMI < 15 kg/m²

(Refer to Page I.12 for chart to help in determining Body Mass Index)

CONTINUE WITH *AGE AT ONSET* NEXT PAGE.

Indicate type of remission by circling the appropriate number:

1 - In partial remission: After full criteria for Anorexia Nervosa were previously met, Criterion A (low body weight) has not been met for a sustained period, but either Criterion B (intense fear of gaining weight or becoming fat or behavior that interferes with weight gain) or Criterion C (disturbances in self-perception of weight and shape) is still met.

2 - In full remission: After full criteria for Anorexia Nervosa were previously met, none of the criteria have been met for a sustained period of time.

When did you last have (ANY SXS OF ANOREXIA NERVOSA)? Number of months prior to interview when last had a symptom of Anorexia Nervosa

?=inadequate information 1=absent or false 2=subthreshold 3=threshold or true
AGE AT ONSET

IF UNKNOWN: How old were you when you first started having (SXS OF ANOREXIA NERVOSA)?

IF ANOREXIA NERVOSA IS NOT CURRENT, GO TO *BULIMIA NERVOSA*.

Do you have eating binges in which you eat a lot of food in a short period of time and feel that your eating is out of control? (How often?)

IF NO: What kinds of things have you done to keep weight off? (Do you ever make yourself vomit or take laxatives, enemas, or water pills? How often?)

Specify subtype for current episode: (circle the appropriate number)

1 – Restricting type:
During the last 3 months, the individual has NOT engaged in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas). This subtype describes presentations in which weight loss is accomplished primarily through dieting, fasting and/or excessive exercise.

2 – Binge-eating/purging type:
During last 3 months, the individual has engaged in recurrent episodes of binge-eating or purging behavior (i.e., self-induced vomiting or misuse of laxatives, diuretics, or enemas).
**BULIMIA NERVOSA***

**BULIMIA NERVOSA CRITERIA**

- **IF SCREENING QUESTION #13 IS ANSWERED “NO,” GO TO *OTHER SPECIFIED FEEDING OR EATING DISORDER* I.10 OR GO TO *ARFID* Opt-I.1.**

- **IF QUESTION #13 ANSWERED “YES”: You’ve said that you’ve had eating binges, that is, times when you couldn’t resist eating a lot of food or stop eating once you’ve started. Tell me about those times.**

- **IF SCREENER NOT USED: Have you had eating binges, that is, times when you couldn’t resist eating a lot of food or stop eating once you started? Tell me about those times.**

**During these times, were you unable to control what or how much you were eating?**

- **A. Recurrent episodes of binge eating. An episode of binge eating is characterized by BOTH of the following:**
  - 1. **Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances**
  - 2. **A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)**

  **NOTE:** Criterion A.2 (lack of control) precedes criterion A.1 to tie in with screening question.

**During those times, how much did you eat? Over what period of time? What’s the most you might eat at such times? (Does this only happen during celebrations or holidays?)**

- **1. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances**

- **2. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)**

**CRITERIA A.2 AND A.1 ARE CODED “3”**

- **IF LIFETIME RATING OF “3” FOR BOTH CRITERIA A.2 AND A.1: During the past 3 months, since (3 MONTHS AGO), have you had such episodes?**

? = inadequate information  
1 = absent or false  
2 = subthreshold  
3 = threshold or true
Have you ever done anything to keep yourself from gaining weight because of the binge eating (like making yourself vomit, taking laxatives, enemas, water pills, or thyroid hormone, strict dieting or fasting, or exercising a lot)? Tell me about that. How often did this occur?

If lifetime rating of "3": Have you done (compensatory behavior[s]) during the past 3 months, since (3 months ago)?

How often were you binge eating and (compensatory behavior[s])? (At least once a week for at least 3 months?)

If lifetime rating of "3": Since (3 months ago), how often were you binge eating and (compensatory behavior[s])? At least once a week?

Has your body shape and weight ever been an important factor in how you felt about yourself?

If yes: How important?

If lifetime rating of "3": Has this also been the case during the past 3 months?

If unknown: Do you binge eat and then (engage in compensatory behavior) only when your weight is very low?

B. Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as: self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.

If lifetime rating of "3": Have you done (compensatory behavior[s]) during the past 3 months, since (3 months ago)?

C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least once a week for 3 months.

D. Self-evaluation is unduly influenced by body shape and weight.

If lifetime rating of "3": Has this also been the case during the past 3 months?

E. The disturbance does not occur exclusively during episodes of Anorexia Nervosa.

Bulimia Nervosa Criteria
A, B, C, D, and E are coded "3."

Bulimia Nervosa

Feeding and Eating Disorders

? = inadequate information  1 = absent or false  2 = subthreshold  3 = threshold or true
**BULIMIA NERVOSA CHRONOLOGY**

BULIMIA NERVOSA CRITERIA
A, B, C, AND D ARE MET FOR
THE PAST 3 MONTHS

Indicate current severity by circling appropriate number: (The level of severity may be increased to reflect other symptoms and the degree of functional disability.)

1 - **Mild:** An average of 1–3 episodes of inappropriate compensatory behaviors per week.
2 - **Moderate:** An average of 4–7 episodes of inappropriate compensatory behaviors per week.
3 - **Severe:** An average of 8–13 episodes of inappropriate compensatory behaviors per week.
4 - **Extreme:** An average of 14 or more episodes of inappropriate compensatory behaviors per week.

CONTINUE WITH **AGE AT ONSET** BELOW.

Indicate type of remission by circling the appropriate number:

1 - **In partial remission:** After full criteria for bulimia nervosa were previously met, some, but not all, of the criteria have been met for a sustained period of time.
2 - **In full remission:** After full criteria for bulimia nervosa were previously met, none of the criteria have been met for a sustained period of time.

When did you last have (ANY SXS OF BULIMIA NERVOSA)?
Number of months prior to interview when last had a symptom of Bulimia Nervosa ______ ______ ______

**AGE AT ONSET**

IF UNKNOWN: **How old were you when you first started having** (SXS OF BULIMIA NERVOSA)?
Age at onset of Bulimia Nervosa (CODE 99 IF UNKNOWN) ______ ______

GO TO **OTHER SPECIFIED FEEDING OR EATING DISORDER** 1.10 OR GO TO **ARFID** Opt-I.1

? = inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true
**BINGE-EATING DISORDER**

During these binges did you...

...eat much more rapidly than normal?

_IF LIFETIME RATING OF "3" AND CURRENTLY BINGE EATING: Has this also been the case during the past 3 months?_

1. Eating much more rapidly than normal.  
   ? 1 2 3 133

Past 3 months  
1 3 134

...ever eat until you felt uncomfortably full?

_IF LIFETIME RATING OF "3" AND CURRENTLY BINGE EATING: Has this also been the case during the past 3 months?_

2. Eating until feeling uncomfortably full.  
   ? 1 2 3 135

Past 3 months  
1 3 136

...ever eat large amounts of food when you didn’t feel physically hungry?

_IF LIFETIME RATING OF "3" AND CURRENTLY BINGE EATING: Has this also been the case during the past 3 months?_

3. Eating large amounts of food when not feeling physically hungry.  
   ? 1 2 3 137

Past 3 months  
1 3 138

...ever eat alone because you were embarrassed by how much you were eating?

_IF LIFETIME RATING OF "3" AND CURRENTLY BINGE EATING: Has this also been the case during the past 3 months?_

4. Eating alone because of being embarrassed by how much one is eating.  
   ? 1 2 3 139

Past 3 months  
1 3 140

...ever feel disgusted with yourself, depressed, or feel very guilty after overeating?

_IF LIFETIME RATING OF "3" AND CURRENTLY BINGE EATING: Has this also been the case during the past 3 months?_

5. Feeling disgusted with oneself, depressed or very guilty afterward.  
   ? 1 2 3 141

Past 3 months  
1 3 142

AT LEAST 3 "B" SXS CODED "3."

1 3 143

GO TO *OTHER SPECIFIED FEEDING OR EATING DISORDER* I.10 OR GO TO *ARFID* Opt-I.1

AT LEAST 3 "B" SXS CODED 3 FOR PAST 3 MONTHS  
1 3 144

?=inadequate information  
1=absent or false  
2=subthreshold  
3=threshold or true
SCID-RV (for DSM-5®) (Version 1.0.0) Binge-Eating Disorder Feeding and Eating Disorders  I.8

Was it very upsetting to you that you couldn’t stop eating or control what or how much you were eating?

C. Marked distress regarding binge eating is present.

IF LIFETIME RATING OF “3” AND CURRENTLY BINGE EATING: For the past 3 months, since (3 MONTHS AGO), has this still been the case?

IF UNKNOWN: How often did you binge eat? (For how long a period of time? At least once a week for at least 3 months?)

D. The binge eating occurs, on average, at least once a week for 3 months.

IF LIFETIME RATING OF “3” AND CURRENTLY BINGE EATING: How often have you been binge eating since (3 MONTHS AGO)? (At least once a week?)

IF UNKNOWN OR UNCLEAR: Did you ever do anything to keep yourself from gaining weight because of the binge eating (like making yourself vomit, taking laxatives, enemas, water pills, or thyroid hormone, strict dieting or fasting, or exercising a lot)?

IF UNKNOWN: Do you binge eat only when your weight is very low?

IF LIFETIME RATING OF “3,” CURRENTLY BINGE EATING AND UNCLEAR: During the past 3 months, since (3 MONTHS AGO), have you done anything to keep yourself from gaining weight because of the binge eating (like making yourself vomit, taking laxatives, enemas, water pills, or thyroid hormone, strict dieting or fasting, or exercising a lot)?

E. The binge eating is not associated with the recurrent use of inappropriate compensatory behaviors as in Bulimia Nervosa and does not occur exclusively during the course of Bulimia Nervosa or Anorexia Nervosa.

NOTE: Code “3” if no recurrent inappropriate compensatory behaviors.

BINGE-EATING DISORDER CRITERIA A, B, C, D, AND E ARE CODED “3.”

NOTE: Criterion A for Binge-Eating Disorder has already been coded “3” as part of the assessment for Bulimia Nervosa, I.4.

?=inadequate information  1=absent or false  2=subthreshold  3=threshold or true
### Binge-Eating Disorder Chronology*

Binge-Eating Disorder criteria A, B, C, D, and E are coded "3" for the past 3 months.

<table>
<thead>
<tr>
<th>PAST BINGE-EATING DISORDER</th>
<th>CURRENT BINGE-EATING DISORDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>?</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>152</td>
</tr>
</tbody>
</table>

*Indicate current severity:* (circle the appropriate number)
(The level of severity may be increased to reflect other symptoms and the degree of functional disability.)

1 - **Mild:** 1–3 binge-eating episodes per week  
2 - **Moderate:** 4–7 binge-eating episodes per week  
3 - **Severe:** 8–13 binge-eating episodes per week  
4 - **Extreme:** 14 or more binge-eating episodes per week

CONTINUE WITH *AGE AT ONSET* BELOW.

*Indicate type of remission:* (circle the appropriate number)

1 - **In partial remission:** After full criteria for Binge-Eating Disorder were previously met, binge eating occurs at an average frequency of less than one episode per week for a sustained period of time.
2 - **In full remission:** After full criteria for Binge-Eating Disorder were previously met, none of the criteria have been met for a sustained period of time.

**When did you last have (ANY SXS OF BINGE-EATING DISORDER)?**  
Number of months prior to interview when last had a symptom of Binge-Eating Disorder

---

**AGE AT ONSET**

*IF UNKNOWN: How old were you when you first started having (SXS OF BINGE-EATING DISORDER)?*  
Age at onset of Binge-Eating Disorder (CODE 99 IF UNKNOWN)
*OTHER SPECIFIED FEEDING OR EATING DISORDER*

Symptoms characteristic of a Feeding and Eating Disorder predominate but do not meet the full criteria for any of the disorders in the Feeding and Eating Disorders diagnostic class.

**IF UNKNOWN:** What effect have (EATING SXS) had on your life?

ASK THE FOLLOWING QUESTIONS AS NEEDED TO RATE CRITERION:

How have (EATING SXS) affected your relationships or your interactions with other people? (Have [EATING SXS] caused you any problems in your relationships with your family, romantic partner or friends?)

How have (EATING SXS) affected your school/work? (How about your attendance at work or school? Have [EATING SXS] made it more difficult to do your work/schoolwork? How have [EATING SXS] affected the quality of your work/schoolwork?)

How have (EATING SXS) affected your ability to take care of things at home? How about doing other things that were important to you like religious activities, physical exercise, or hobbies? Have you avoided doing anything because you felt like you weren't up to it?

Have (EATING SXS) affected any other important part of your life?

**IF HAVE NOT INTERFERED WITH LIFE:** How much were you bothered or upset by having (EATING SXS)?

**IF UNCLEAR:** During the past month, since (1 MONTH AGO), have you had (SXS OF EATING DISORDER)? Check here ___ if present in the past month.

1 = absent or false  
2 = subthreshold  
3 = threshold or true
Indicate type of Other Specified Eating Disorder: (circle the appropriate number)

1 - **Atypical anorexia nervosa:** All of the criteria for Anorexia Nervosa are met, except that despite significant weight loss, the individual’s weight is within or above the normal range.

2 - **Bulimia nervosa (of low frequency and/or limited duration):** All of the criteria for Bulimia Nervosa are met, except that the binge eating and inappropriate compensatory behaviors occur, on average, less than once a week and/or for less than 3 months.

3 - **Binge-eating disorder (of low frequency and/or limited duration):** All of the criteria for Binge-Eating Disorder are met, except that the binge eating occurs, on average, less than once a week and/or for less than 3 months.

4 - **Purging disorder:** Recurrent purging behavior to influence weight or shape (e.g., self-induced vomiting; misuse of laxatives, diuretics, or other medications) in the absence of binge eating.

5 - **Night eating syndrome:** Recurrent episodes of night eating, as manifested by eating after awakening from sleep or by excessive food consumption after the evening meal. There is awareness and recall of the eating. The night eating is not better explained by external influences such as changes in the individual's sleep-wake cycle or by local social norms. The night eating causes significant distress and/or impairment in functioning. The disordered pattern of eating is not better explained by Binge-Eating Disorder or another mental disorder, including substance use, and is not attributable to another medical disorder or to an effect of medication.

6 - **Other:**

7 - **Unspecified:** There is insufficient information to make a more specific diagnosis.
### TABLE FOR DETERMINING SEVERITY OF ANOREXIA NERVOSA BASED ON BODY MASS INDEX

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Height (inches)</td>
<td>Body Weight (kg)</td>
<td>Body Weight (pounds)</td>
<td>Body Weight (kg)</td>
<td>Body Weight (pounds)</td>
</tr>
<tr>
<td>148 (58&quot; / 4’10&quot;)</td>
<td>≥38 (≥84)</td>
<td>35-37 (77-82)</td>
<td>33-34 (72-76)</td>
<td>&lt;33 (&lt;72)</td>
</tr>
<tr>
<td>150 (59&quot; / 4’11&quot;)</td>
<td>≥39 (≥86)</td>
<td>37-38 (79-81)</td>
<td>35-36 (74-78)</td>
<td>&lt;35 (&lt;74)</td>
</tr>
<tr>
<td>153 (60&quot; / 5’)</td>
<td>≥40 (≥90)</td>
<td>38-39 (84-87)</td>
<td>36-37 (77-81)</td>
<td>&lt;36 (&lt;77)</td>
</tr>
<tr>
<td>155 (61&quot; / 5’1&quot;)</td>
<td>≥41 (≥95)</td>
<td>39-40 (86-90)</td>
<td>37-38 (80-85)</td>
<td>&lt;37 (&lt;80)</td>
</tr>
<tr>
<td>158 (62&quot; / 5’2&quot;)</td>
<td>≥43 (≥95)</td>
<td>41-42 (89-93)</td>
<td>38-39 (82-88)</td>
<td>&lt;38 (&lt;82)</td>
</tr>
<tr>
<td>160 (63&quot; / 5’3&quot;)</td>
<td>≥44 (≥97)</td>
<td>42-43 (92-96)</td>
<td>39-40 (85-91)</td>
<td>&lt;39 (&lt;85)</td>
</tr>
<tr>
<td>163 (64&quot; / 5’4&quot;)</td>
<td>≥46 (≥101)</td>
<td>44-45 (97-99)</td>
<td>40-41 (88-92)</td>
<td>&lt;40 (&lt;88)</td>
</tr>
<tr>
<td>165 (65&quot; / 5’5&quot;)</td>
<td>≥47 (≥104)</td>
<td>45-46 (100-102)</td>
<td>41-43 (91-95)</td>
<td>&lt;41 (&lt;91)</td>
</tr>
<tr>
<td>168 (66&quot; / 5’6&quot;)</td>
<td>≥48 (≥106)</td>
<td>46-47 (100-105)</td>
<td>43-44 (93-99)</td>
<td>&lt;43 (&lt;93)</td>
</tr>
<tr>
<td>170 (67&quot; / 5’7&quot;)</td>
<td>≥49 (≥108)</td>
<td>47-48 (103-107)</td>
<td>44-46 (95-102)</td>
<td>&lt;44 (&lt;95)</td>
</tr>
<tr>
<td>173 (68&quot; / 5’8&quot;)</td>
<td>≥51 (≥112)</td>
<td>49-50 (104-109)</td>
<td>46-47 (97-103)</td>
<td>&lt;46 (&lt;97)</td>
</tr>
<tr>
<td>175 (69&quot; / 5’9&quot;)</td>
<td>≥52 (≥115)</td>
<td>50-51 (106-113)</td>
<td>47-48 (99-105)</td>
<td>&lt;47 (&lt;99)</td>
</tr>
<tr>
<td>178 (70&quot; / 5’10&quot;)</td>
<td>≥54 (≥119)</td>
<td>52-53 (109-116)</td>
<td>48-50 (102-108)</td>
<td>&lt;48 (&lt;102)</td>
</tr>
<tr>
<td>180 (71&quot; / 5’11&quot;)</td>
<td>≥55 (≥121)</td>
<td>53-54 (115-123)</td>
<td>51-52 (108-114)</td>
<td>&lt;51 (&lt;108)</td>
</tr>
<tr>
<td>183 (72&quot; / 6’0&quot;)</td>
<td>≥57 (≥126)</td>
<td>54-55 (119-125)</td>
<td>52-53 (111-118)</td>
<td>&lt;52 (&lt;111)</td>
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<tr>
<td>185 (73&quot; / 6’1&quot;)</td>
<td>≥58 (≥128)</td>
<td>55-57 (124-129)</td>
<td>53-54 (114-121)</td>
<td>&lt;53 (&lt;114)</td>
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<tr>
<td>188 (74&quot; / 6’2&quot;)</td>
<td>≥60 (≥132)</td>
<td>57-59 (125-132)</td>
<td>54-55 (117-124)</td>
<td>&lt;54 (&lt;117)</td>
</tr>
<tr>
<td>191 (75&quot; / 6’3&quot;)</td>
<td>≥61 (≥134)</td>
<td>59-60 (128-136)</td>
<td>55-58 (122-127)</td>
<td>&lt;55 (&lt;122)</td>
</tr>
<tr>
<td>193 (76&quot; / 6’4&quot;)</td>
<td>≥63 (≥140)</td>
<td>60-62 (132-140)</td>
<td>58-59 (123-131)</td>
<td>&lt;58 (&lt;123)</td>
</tr>
</tbody>
</table>

**Source:** Adapted from Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report.
L. TRAUMA- AND STRESSOR-RELATED DISORDERS

TRAUMA HISTORY

I'd now like to ask about some things that may have happened to you that may have been extremely upsetting. People often find that talking about these experiences can be helpful. I'll start by asking if these experiences apply to you, and if so, I'll ask you to briefly describe what happened and how you felt at the time.

SCREEN FOR EACH TYPE OF TRAUMA USING QUESTIONS BELOW; THEN, ON PAGES L.2-L.5 REVIEW AND INQUIRE IN DETAIL FIRST FOR ANY EVENTS OCCURRING IN THE PAST MONTH AND THEN FOR UP TO THREE PAST EVENTS (E.G., THREE WORST EVENTS, THREE MOST RECENT EVENTS, ETC.)

Have you ever been in a life threatening situation like a major disaster or fire, combat, or a serious car or work-related accident?

What about being physically or sexually assaulted or abused, or threatened with physical or sexual assault?

How about seeing another person being physically or sexually assaulted or abused, or threatened with physical or sexual assault?

Have you ever seen another person killed or dead, or badly hurt?

How about learning that one of these things happened to someone you are close to?

IF UNKNOWN: Have you ever been the victim of a serious crime?

IF NO EVENTS ENDORSED: What would you say has been the most stressful or traumatic experience you have had over your life?

IF NO EVENTS ACKNOWLEDGED, CHECK HERE ___ AND GO TO *ADJUSTMENT DISORDER* L.20. OTHERWISE CONTINUE ON NEXT PAGE.

= inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true
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Did any of these happen in the past month, since (1 MONTH AGO)?

IF YES: ASSESS THE TRAUMATIC EVENT IN PAST MONTH USING THE QUESTIONS BELOW.

IF NO: CONTINUE ON TOP OF PAGE L.3.

DETAILS FOR EVENT IN PAST MONTH

IF DIRECT EXPOSURE TO TRAUMA:
What happened? Were you afraid of dying or being seriously hurt? Were you seriously hurt?

IF WITNESSED TRAUMATIC EVENT HAPPENING TO OTHERS:
What happened? What did you see? How close were you to (TRAUMATIC EVENT)? Were you concerned about your own safety?

IF LEARNED ABOUT TRAUMATIC EVENT:
What happened? Who did it involve? (How close [emotionally] were you to them? Did it involve violence, suicide or a bad accident?)

Description of traumatic event:
________________________________
________________________________

Indicate type of traumatic event: (check all that apply)
___ Death, actual
___ Death, threatened
___ Serious Injury, actual
___ Serious injury, threatened
___ Sexual violence, actual
___ Sexual violence, threatened

Indicate mode of exposure to traumatic event: (check all that apply)
___ Directly experienced
___ Witnessed happening to others in person
___ Learning about actual or threatened violence or accidental death of a close family member or friend
___ Repeated or extreme exposure to aversive details of traumatic events (e.g., police officers repeatedly exposed to details of child abuse)

IF UNKNOWN: How old were you at the time?
Age at time of event: ____

IF UNKNOWN: Did this happen more than once?

Indicate type of exposure: (circle the appropriate number)
1 - Single event
2 - Prolonged or repeated exposure to same trauma (e.g., witnessing repeated episodes of parental domestic violence over years

= inadequate information  1 = absent or false  2 = subthreshold  3 = threshold or true
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- **IF NO EVENTS PRIOR TO PAST MONTH, GO TO ** *ACUTE STRESS DISORDER* L.6.

- **IF EVENTS PRIOR TO PAST MONTH, REVIEW THE TYPES OF TRAUMA INDICATED ON SCREENING (PAGE L.1 IN THE STANDARD VERSION OF MODULE L OR PAGES ALT-L.1 THROUGH ALT-L3 IN THE ALTERNATE VERSION) AND CHOOSE THE THREE MOST SEVERE EVENTS TO ASSESS, USING THE FOLLOWING QUESTIONS:**

**DETAILS FOR PAST EVENT #1**

[If Direct Exposure to Trauma:]
What happened? Were you afraid of dying or being seriously hurt? Were you seriously hurt?

[If Witnessed Traumatic Event Happening to Others:]
What happened? What did you see? How close were you to (TRAUMATIC EVENT)? Were you concerned about your own safety?

[If Learned About Traumatic Event:]
What happened? Who did it involve? (How close [emotionally] were you to them? Did it involve violence, suicide or a bad accident?)

**Description** of traumatic event:

________________________________
________________________________

**Indicate type of traumatic event:** (check all that apply)

___ Death, actual L23
___ Death, threatened L24
___ Serious Injury, actual L25
___ Serious injury, threatened L26
___ Sexual violence, actual L27
___ Sexual violence, threatened L28

**Indicate mode of exposure to traumatic event:** (check all that apply)

___ Directly experienced L29
___ Witnessed happening to others in person L30
___ Learning about actual or threatened violence or accidental death of a close family member or friend L31
___ Repeated or extreme exposure to aversive details of traumatic events (e.g., police officers repeatedly exposed to details of child abuse) L32

**IF UNKNOWN: How old were you at the time?**

Age at time of event: _____

**IF UNKNOWN: Did this happen more than once?**

**Indicate type of exposure:** (circle the appropriate number)

1 – Single event L34

2 – Prolonged or repeated exposure to same trauma (e.g., witnessing repeated episodes of parental domestic violence over years)

=inadequate information  1=absent or false  2=subthreshold  3=threshold or true

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DETAILS FOR PAST EVENT #2

 IF DIRECT EXPOSURE TO TRAUMA:
What happened? Were you afraid of dying or being seriously hurt? Were you seriously hurt?

 IF WITNESSED TRAUMATIC EVENT HAPPENING TO OTHERS:
What happened? What did you see? How close were you to (TRAUMATIC EVENT)? Were you concerned about your own safety?

 IF LEARNED ABOUT TRAUMATIC EVENT:
What happened? Who did it involve? (How close [emotionally] were you to them? Did it involve violence, suicide or a bad accident?)

 Description of traumatic event:

________________________________________________________________________
________________________________________________________________________

 Indicate type of traumatic event: (check all that apply):

___ Death, actual
___ Death, threatened
___ Serious Injury, actual
___ Serious injury, threatened
___ Sexual violence, actual
___ Sexual violence, threatened

 Indicate mode of exposure to traumatic event: (check all that apply)

___ Directly experienced
___ Witnessed happening to others in person
___ Learning about actual or threatened violence or accidental death of a close family member or friend
___ Repeated or extreme exposure to aversive details of traumatic events (e.g., police officers repeatedly exposed to details of child abuse)

 IF UNKNOWN: How old were you at the time?

Age at time of event: ___

 IF UNKNOWN: Did this happen more than once?

 Indicate type of exposure: (circle the appropriate number)

1 – Single event

2 – Prolonged or repeated exposure to same trauma (e.g., witnessing repeated episodes of parental domestic violence over years

= inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true
DETAILS FOR PAST EVENT #3

IF DIRECT EXPOSURE TO TRAUMA:
What happened? Were you afraid of dying or being seriously hurt? Were you seriously hurt?

IF WITNESSED TRAUMATIC EVENT HAPPENING TO OTHERS:
What happened? What did you see? How close were you to (TRAUMATIC EVENT)? Were you concerned about your own safety?

IF LEARNED ABOUT TRAUMATIC EVENT:
What happened? Who did it involve? (How close [emotionally] were you to them? Did it involve violence, suicide or a bad accident?)

Description of traumatic event:
________________________________
________________________________

Indicate type of traumatic event: (check all that apply)
___ Death, actual
___ Death, threatened
___ Serious Injury, actual
___ Serious injury, threatened
___ Sexual violence, actual
___ Sexual violence, threatened

Indicate mode of exposure to traumatic event: (check all that apply)
___ Directly experienced
___ Witnessed happening to others in person
___ Learning about actual or threatened violence or accidental death of a close family member or friend
___ Repeated or extreme exposure to aversive details of traumatic events (e.g., police officers repeatedly exposed to details of child abuse)

IF UNKNOWN: How old were you at the time?

Age at time of event: _____

IF UNKNOWN: Did this happen more than once?

Indicate type of exposure: (circle the appropriate number)

1 – Single event

2 – Prolonged or repeated exposure to same trauma (e.g., witnessing repeated episodes of parental domestic violence over years)

= inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true
**ACUTE STRESS DISORDER (CURRENT ONLY)**

*IF NO EVENTS IN PAST MONTH, CHECK HERE ___ AND GO TO *POSTTRAUMATIC STRESS DISORDER* L.11*

REVIEW TRAUMATIC EVENTS OCCURRING IN THE PAST MONTH DESCRIBED IN DETAIL ON PAGE L.2.

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s). ? 1 2 3 L62
2. Witnessing, in person, the event(s) as it occurred to others. ? 1 2 3 L63
3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental. ? 1 2 3 L64
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse) ? 1 2 3 L65

**Note:** Criterion A.4 does not apply to exposure through electronic media, television, movies, or pictures, unless the exposure is work-related.

AT LEAST ONE A ITEM CODED "3" 1 3 L66

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

Since (1 MONTH AGO)... 

...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?) 1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). ? 1 2 3 L67

...what about having upsetting dreams that remind you of (TRAUMATIC EVENT)? Tell me about that. 2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event. ? 1 2 3 L68

= inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true
Since (1 MONTH AGO)...  

...what about finding yourself acting or feeling as if you were back in the situation? (Have you had “flashbacks” of [TRAUMATIC EVENT]?)

...have you had a strong emotional or physical reaction when something reminded you of [TRAUMATIC EVENT]? Give me some examples of the kinds of things that would trigger this reaction. (Things like...seeing a person who resembles the person who attacked you, hearing the screech of brakes if you were in a car accident, hearing the sound of helicopters if you were in combat, any kind of physically intimacy in someone who was raped?)

*IF YES:* What kind of reaction did you have? Did you get very upset or stay upset for a while, even after the reminder had gone away? (What about having physical symptoms—like breaking out in a sweat, breathing heavily or irregularly, or feeling your heart pound or race when something reminded you of [TRAUMATIC EVENT]? How about feeling tense or shaky?)

...have you been unable to experience good feelings, like feeling happy, joyful, satisfied, loving, or tender towards other people?

*IF YES:* Is this different from the way you were before (TRAUMATIC EVENT)?

...have you had the feeling that you were in a daze, that everything was unreal or that you were in a dream, that you were detached from your own body or mind, that time was moving more slowly, or that you were an outside observer of your own thoughts or movements?

...have you been unable to remember some important part of what happened?

*IF YES:* Did you get a head injury during (TRAUMATIC EVENT)? Were you drinking a lot or were you taking any drugs at the time of (TRAUMATIC EVENT)?

...have you done things to avoid remembering or thinking about (TRAUMATIC EVENT) like keeping yourself busy, distracting yourself like by playing computer or video games or watching TV, or using drugs or alcohol to “numb” yourself or to try to forget what happened?

*IF NO:* How about doing things to avoid having feelings similar to those you had during (TRAUMATIC EVENT)?

3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)

4. Intense or prolonged psychological distress or marked physiological reactions in response to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

5. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

6. An altered sense of reality of one’s surroundings or one’s self (e.g., seeing oneself from another’s perspective, being in a daze, time slowing).

7. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).

8. Efforts to avoid distressing memories, thoughts, or feelings about or closely related with traumatic event(s).
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Acute Stress Disorder  

Trauma-/Stressor-Related Disorders  

L.8

Since (1 MONTH AGO)...

...have there been things, places, or people that you have tried to avoid because it brought up upsetting memories, thoughts, or feelings about (TRAUMATIC EVENT)?

IF NO: How about avoiding certain activities, situations, or topics of conversation?

...how have you been sleeping since (TRAUMATIC EVENT)? (Is this a change from before [TRAUMATIC EVENT]?)

...have you lost control of your anger, so that you threatened or hurt someone or damaged something? Tell me what happened. (Was it over something little or even nothing at all?)

IF NO: Since (TRAUMATIC EVENT), have you been more quick-tempered or had a shorter “fuse” than before?

IF YES TO EITHER: How different is this from the way you were before (TRAUMATIC EVENT)?

...have you noticed that you have been more watchful or on guard since (TRAUMATIC EVENT)? (What are some examples?)

IF NO: Have you been extra aware of your surroundings and your environment?

...have you had trouble concentrating? (What are some examples? Is this a change from before [TRAUMATIC EVENT]?)

...have you been jumpy or easily startled, like by sudden noises? (Is this a change from before [TRAUMATIC EVENT]?)

AT LEAST NINE “B” SXS ARE CODED “3.”

About how long did (“B” SXS CODED “3”) last altogether?

C. Duration of the disturbance (symptoms in Criterion B) is 3 days to 1 month after trauma exposure.

GO TO *PTSD* L.11

= inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true
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**Acute Stress Disorder**  

**Trauma-/Stressor-Related Disorders**  

L.9  

**IF UNKNOWN:** What effect have (ASD SXS) had on your life?  

**ASK THE FOLLOWING QUESTIONS AS NEEDED TO RATE CRITERION D:**  

How have (ASD SXS) affected your relationships or your interactions with other people? (Have they caused you any problems in your relationships with your family, romantic partner or friends?)  

How have (ASD SXS) affected your work/school? (How about your attendance at work or school? Have they affected the quality of your work/schoolwork?)  

How have they affected your ability to take care of things at home? What about being involved in things that are important to you, like religious activities, physical exercise, or hobbies?  

Have (ASD SXS) affected any other important part of your life?  

**IF HAVE NOT INTERFERED WITH LIFE:** How much have you been bothered or upset by (ASD SXS)?  

Did (TRAUMATIC EVENT) cause any injury to your head or brain?  

Have you been drinking a lot or using a lot of drugs since (TRAUMATIC EVENT)? Tell me about that. (How much have you been [drinking/using (DRUG[S])]? (Do you think your problems since [TRAUMATIC EVENT] are more due to your [drinking/(DRUG) use] rather than to your reaction to [TRAUMATIC EVENT] itself?)  

**IF PSYCHOTIC:** Have you had (ASD SXS) only when you were (PSYCHOTIC SXS)?  

D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.  

? 1 2 3  

GO TO *PTSD* L.11  

E. The disturbance is not attributable to the physiological effects of a substance (e.g., medication or alcohol) or another medical condition (e.g., mild traumatic brain injury) and is not better explained by Brief Psychotic Disorder.  

GO TO *PTSD* L.11  

= inadequate information  
1 = absent or false  
2 = subthreshold  
3 = threshold or true
ACUTE STRESS DISORDER CRITERIA A, B, C, D, AND E ARE CODED “3.”

IF UNKNOWN: Have you had any panic attacks in the past month?

___ With panic attacks: if one or more panic attacks in the past month occurring in the context of current Acute Stress Disorder (see page F.7) and criteria have never been met for Panic Disorder.
POSTTRAUMATIC STRESS DISORDER

FOR FOLLOWING QUESTIONS, FOCUS ON THE THREE MOST SEVERE TRAUMATIC EVENT(S) DESCRIBED ON PAGES L.3–L.5.

IF ALL TRAUMAS ARE CONFINED TO THE PAST MONTH, CHECK HERE ___ AND SKIP TO *ADJUSTMENT DISORDER* PAGE L.20.

IF MORE THAN ONE TRAUMATIC EVENT IS REPORTED: Which of these do you think affected you the most?

IF SELECTED EVENT IS ULTIMATELY NOT ASSOCIATED WITH THE FULL PTSD SYNDROME, CONSIDER RE-ASSESSING THE ENTIRE PTSD CRITERIA SET (PAGES L.11–L.17) FOR OTHER REPORTED TRAUMAS.

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).

2. Witnessing, in person, the event(s) as it occurred to others.

3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.

4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse).

Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless the exposure is work-related.

AT LEAST ONE A ITEM CODED “3”

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

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?

...what about having upsetting dreams that reminded you of (TRAUMATIC EVENT)? Tell me about that.

IF LIFETIME RATING OF “3”: Has this also happened in the past month? 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).

2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event.

=inadequate information 1=absent or false 2=subthreshold 3=threshold or true
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PTSD Trauma- and Stressor-Related Disorders L.12

3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)

IF LIFETIME RATING OF "3": Has this also happened in the past month? How many times?

4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

IF YES:
What kind of reaction did you have? Did you get very upset or stay upset for a while, even after the reminder had gone away?

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

5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

IF ACKNOWLEDGES STRONG EMOTIONAL OR PHYSICAL REACTION: What about having physical symptoms—like breaking out in a sweat, breathing heavily or irregularly, or feeling your heart pound or race when something reminded you of (TRAUMATIC EVENT)? How about feeling tense or shaky?

IF LIFETIME RATING OF "3": Has this also happened in the past month? How many times?

AT LEAST ONE "B" SX IS CODED "3."

GO TO *ADJUSTMENT DISORDER* L.20

CRITERION B MET PAST MONTH: 1 3

= inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true
SCID-RV (for DSM-5®) (Version 1.0.0) PTSD Trauma- and Stressor-Related Disorders L.13

Since (TRAUMATIC EVENT)... 

...have you done things to avoid remembering or thinking about (TRAUMATIC EVENT) like keeping yourself busy, distracting yourself like by playing computer or video games or watching TV, or using drugs or alcohol to "numb" yourself or try to forget what happened? (Since [TRAUMATIC EVENT], how long has this gone on?)

IF NO: How about doing things to avoid having feelings similar to those you had during (TRAUMATIC EVENT)? (Since [TRAUMATIC EVENT], how long has this gone on?)

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

...have there been things, places, or people that you have tried to avoid because it brought up upsetting memories, thoughts, or feelings about (TRAUMATIC EVENT)? (Since [TRAUMATIC EVENT], how long has this gone on?)

IF NO: How about avoiding certain activities, situations, or topics of conversation? (Since [TRAUMATIC EVENT], how long has this gone on?)

IF LIFETIME RATING OF "3": Has this also happened in the past month? How many times?

AT LEAST ONE "C" SX IS CODED "3."

GO TO *ADJUSTMENT DISORDER* L.20

CRITERION C MET PAST MONTH:

199
Since (TRAUMATIC EVENT)...

...have you been unable to remember some important part of what happened? (Tell me about that.)

**IF YES:** Did you get a head injury during (TRAUMATIC EVENT)? Were you drinking a lot or were taking any drugs at the time of (TRAUMATIC EVENT)?

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

...has there been a change in how you think about yourself? (Like feeling you are “bad,” or permanently damaged or “broken?” Tell me about that. Since this started, have you felt this way most of the time?)

**IF NO:** Has there been a change in how you see other people or the way the world works? (Like you can’t trust anyone anymore? Like the world is a completely dangerous place? Tell me about that. Since this started, have you felt this way most of the time?)

**IF LIFETIME RATING OF "3":** Has this also happened in the past month? How much of the time?

...have you blamed yourself for the (TRAUMATIC EVENT) or how it affected your life? (Like feeling that (TRAUMATIC EVENT) was your fault or that you should have done something to prevent it? Like feeling that you should have gotten over it by now?)

**IF YES:** Tell me about that. (Since this started, have you felt this way most of the time?)

**IF NO:** Have you blamed someone else for (TRAUMATIC EVENT)? Tell me about that. (What did they have to do with [TRAUMATIC EVENT]?)

**IF LIFETIME RATING OF "3":** Has this also happened in the past month? How much of the time?

...have you had bad feelings much of the time, like feeling sad, angry, afraid, guilty, ashamed, “in shock”? (Tell me about that.)

**IF YES:** Is this different from the way you were before (TRAUMATIC EVENT)?

**IF LIFETIME RATING OF "3":** Has this also happened in the past month? How many times?

1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).

2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., “I am bad,” “No one can be trusted,” “The world is completely dangerous,” “My whole nervous system is permanently ruined”).

3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.

4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).

= inadequate information  1 = absent or false  2 = subthreshold  3 = threshold or true
**SCID-RV (for DSM-5®) (Version 1.0.0)**

**PTSD**

**Trauma- and Stressor-Related Disorders L.15**

**Since (TRAUMATIC EVENT)...**

...have you been less interested in things that you were interested in before (TRAUMATIC EVENT), like spending time with family or friends, reading books, watching TV, cooking, or sports? (Tell me about that.)

*IF NO LOSS OF INTEREST:* Are you still doing as many activities as you used to?

*IF LIFETIME RATING OF "3":* Has this also happened in the past month? How many times?

...have you felt distant or disconnected from others or have you closed yourself off from other people? (Tell me about that.)

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

...have you been unable to experience good feelings, like feeling happy, joyful, satisfied, loving, or tender towards other people? (Tell me about that.)

*IF YES:* Is this different from the way you were before (TRAUMATIC EVENT)?

*IF LIFETIME RATING OF "3":* Has this also happened in the past month? How often?

**E.** Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.

*IF NO:* Since (TRAUMATIC EVENT), have you been more quick-tempered or had a shorter "fuse" than before?

*IF YES TO EITHER:* How different is this from the way you were before (TRAUMATIC EVENT)?

*IF LIFETIME RATING OF "3":* Has this also happened in the past month, since (1 MONTH AGO)? How often?
SCID-RV (for DSM-5®) (Version 1.0.0) PTSD Trauma- and Stressor-Related Disorders L.16

Since (TRAUMATIC EVENT)...

...have you done reckless things, like driving dangerously, or drinking or using drugs without caring about the consequences?

   IF NO: How about hurting yourself on purpose or trying to kill yourself? (What did you do?)

   IF YES TO EITHER: How different is this from the way you were before (TRAUMATIC EVENT)?

   IF LIFETIME RATING OF "3": Has this also happened in the past month? How often?

...have you noticed that you have been more watchful or on guard? (What are some examples?)

   IF NO: Have you been extra aware of your surroundings and your environment?

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

...have you been jumpy or easily startled, like by sudden noises? (Is this a change from before [TRAUMATIC EVENT]?)

   IF LIFETIME RATING OF "3": Has this also happened in the past month? How often?

...have you had trouble concentrating? (What are some examples? (Is this a change from before [TRAUMATIC EVENT]?)

   IF LIFETIME RATING OF "3": Has this also happened in the past month? How often?

...how have you been sleeping since (TRAUMATIC EVENT)? (Is this a change from before [TRAUMATIC EVENT]?)

   IF LIFETIME RATING OF "3": Has this also happened in the past month? How often?

   2. Reckless or self-destructive behavior.

   NOTE: Any current suicidal thoughts, plans, or actions should be thoroughly assessed by the clinician and action taken if necessary.

   IF LIFETIME RATING OF "3": Has this also happened in the past month? How often?

   Past month
   ? 1 2 3

   L129

   AT LEAST TWO “E” SXS ARE CODED “3.”

   GO TO *ADJUSTMENT DISORDER* L.20

   CRITERION E MET PAST MONTH
   1 3

   L130

   L131

   L132

   L133

   L134

   L135

   L136

   L137

   L138

   L139

   L140

   =inadequate information 1=absent or false 2=subthreshold 3=threshold or true
**PTSD**

**Trauma- and Stressor-Related Disorders** L.17

F. Duration of the disturbance (symptoms in criteria B, C, D, and E) is more than 1 month.

G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

CRITERION H HAS BEEN OMITTED.

**SCID-RV (for DSM-5®) (Version 1.0.0)**

**About how long did these (PTSD SYMPTOMS CODED "3") last altogether?**

**IF UNKNOWN:** What effect did (PTSD SXS) have on your life?

ASK THE FOLLOWING QUESTIONS AS NEEDED TO RATE CRITERION G:

How have (PTSD SXS) affected your relationships or your interactions with other people? (Have they caused you any problems in your relationships with your family, romantic partner or friends?)

How have (PTSD SXS) affected your work/school? (Have they affected the quality of your work/schoolwork?)

How have they affected your ability to take care of things at home? What about being involved in things that are important to you like religious activities, physical exercise, or hobbies?

Have (PTSD SXS) affected any other important part of your life?

**IF HAVE NOT INTERFERED WITH LIFE:** How much have you been bothered or upset by (PTSD SXS)?

**IF LIFETIME RATING OF "3":** How have (PTSD SXS) affected your life in the past month, since (1 MONTH AGO)?

**POSTTRAUMATIC STRESS DISORDER CRITERIA A, B, C, D, E, F, AND G ARE CODED "3."**

= inadequate information  
1 = absent or false  
2 = subthreshold  
3 = threshold or true
PTSD CRITERIA B, C, D, E, AND G MET FOR THE PAST MONTH.

When did you last have (ANY SXS OF PTSD)?

Number of months prior to interview when last had a symptom of PTSD

IF UNKNOWN: How old were you when you first started having (SXS OF PTSD)? Age at onset of Posttraumatic Stress Disorder (CODE 99 IF UNKNOWN).

IF POSTTRAUMATIC STRESS DISORDER IS NOT CURRENT, GO TO *ADJUSTMENT DISORDER* L.20.

IF UNKNOWN: Did most of these problems begin soon after (TRAUMA)? Specify if:

IF NO: How much time was it from the (TRAUMA) and when you had most of these problems? (Was it less than 6 months?) With delayed expression: If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

=inadequate information 1=absent or false 2=subthreshold 3=threshold or true
While you had these problems, did you also often have the feeling that everything was unreal or that you were in a dream, you were detached from your body or mind, that time was moving slowly, or that you were an outside observer of your own thoughts or movements?

**IF YES:** Does this occur at times other than when you are using drugs or alcohol? Does this occur at times other than during a seizure?

**Indicate type:** (circle the appropriate number)

1 – With dissociative symptoms:

The individual’s symptoms meet the criteria for Posttraumatic Stress Disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

- **Depersonalization:** Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one’s mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).

- **Derealization:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).

**Note:** To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

2 – Without dissociative symptoms: If neither 1 nor 2 above.

**Specify if:**

**IF UNKNOWN:** Have you had any panic attacks in the past month?

**With panic attacks:** if one or more panic attacks in the past month occurring in the context of current Posttraumatic Stress Disorder (see page F.7) and criteria have never been met for Panic Disorder.
*ADJUSTMENT DISORDER (CURRENT ONLY)*

CONSIDER THIS SECTION ONLY IF THERE ARE SYMPTOMS OCCURRING IN THE PAST 6 MONTHS THAT DO NOT MEET THE CRITERIA FOR ANOTHER DSM-5 DISORDER. OTHERWISE, CHECK HERE ___ AND GO TO *OTHER SPECIFIED TRAUMA- AND STRESSOR-RELATED DISORDER* L.23. INFORMATION OBTAINED FROM OVERVIEW OF PRESENT ILLNESS WILL USUALLY BE SUFFICIENT TO RATE THE CRITERIA FOR ADJUSTMENT DISORDER.

**ADJUSTMENT DISORDER CRITERIA**

A. The development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s).

DESCRIBE SYMPTOMS:

B. These symptoms or behaviors are clinically significant as evidenced by one or both of the following:

1. Marked distress that is out of proportion to the severity and intensity of the stressor, taking into account the external context and the cultural factors that might influence symptom severity and presentation.

2. Significant impairment in social, occupational, or other important areas of functioning.

GO TO *OTHER SPECIFIED TRAUMA- AND STRESSOR-INDUCED DISORDER* L.23

IF UNKNOWN: Did anything happen to you before (SYMPTOMS) began?

IF YES: Tell me about what happened. Do you think that (STRESSOR) had anything to do with your developing (SXS)?

IF SINGLE EVENT: How long after (STRESSOR) did you first develop (SXS)? (Was it within 3 months?)

IF CHRONIC STRESSOR: How long after (STRESSOR) began did you first develop (SXS)? (Was it within 3 months?)

IF UNKNOWN: What effect did (SXS) have on your life?

ASK THE FOLLOWING QUESTIONS AS NEEDED TO RATE CRITERION B:

How have (SXS) affected your relationships or your interactions with other people? (Have they caused you any problems in your relationships with your family, romantic partner or friends?)

How have (SXS) affected your work/school? (How about your attendance at work or school? Did (SXS) make it more difficult to do your work/schoolwork? How did (SXS) affect the quality of your work/schoolwork?)

How have they affected your ability to take care of things at home? What about being involved in things that are important to you like religious activities, physical exercise, or hobbies?

Have (SXS) affected any other important part of your life?

IF HAVE NOT INTERFERED WITH LIFE: How much have you been bothered or upset by having (SXS)? How upset are you about (STRESSOR)? (Are you more upset than most other people would be? Have others said that you’re more upset than you should be? Have (SXS) lasted longer than you or other people think they should have?)

= inadequate information 1= absent or false 2= subthreshold 3= threshold or true
Have you had this kind of reaction many times before?

**IF UNKNOWN:** Were you having these (SXS) even before (STRESSOR) happened?

**IF UNKNOWN:** Did someone close to you die just before (SXS)?

**IF UNKNOWN:** How long has it been since (STRESSOR AND ITS CONSEQUENCES) was over?

C. The stress-related disturbance does not meet the criteria for another mental disorder and is not merely an exacerbation of a preexisting mental [including personality] disorder.

D. The symptoms do not represent normal bereavement.

E. Once the stressor (or its consequences) has terminated, the symptoms do not persist for more than an additional 6 months.
ADJUSTMENT DISORDER CRITERIA A, B, C, D, AND E ARE CODED "3" DURING THE PAST 6 MONTHS.

Indicate type based on predominant symptoms: (circle the appropriate number)

1 - With depressed mood: Low mood, tearfulness, or feelings of hopelessness are predominant.

2 - With anxiety: Nervousness, worry, jitteriness, or separation anxiety is predominant.

3 - With mixed anxiety and depressed mood: A combination of depression and anxiety is predominant.

4 - With disturbance of conduct: Disturbance in conduct is predominant.

5 - With mixed disturbance of emotions and conduct: Both emotional symptoms (e.g., depression, anxiety) and a disturbance of conduct are predominant.

6 - Unspecified: For maladaptive reactions that are not classifiable as one of the specific subtypes of adjustment disorder (e.g., physical complaints, social withdrawal, or work or academic inhibition).

IF UNKNOWN: When did (SXS) begin? Specify if: (circle the appropriate number)

1 - Acute: if the disturbance lasts less than 6 months.

2 - Persistent (chronic): if the disturbance lasts for 6 months or longer.
**OTHER SPECIFIED TRAUMA- AND STRESSOR-RELATED DISORDER**

*Symptoms characteristic of a Trauma- and Stressor-Related Disorder predominate but do not meet the full criteria for any of the disorders in the Trauma- and Stressor-Related Disorders diagnostic class.*

[Symptoms] that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

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**OTHER SPECIFIED TRAUMA- AND STRESSOR-RELATED DISORDER**

*If unknown: What effect did (SXS of Trauma- and Stressor-Related to Stressor) have on your life?*

Ask the following questions as needed to rate criterion:

*How did (SXS of Trauma- and Stressor-Related Disorder) affect your relationships or your interactions with other people? (Did [SXS of Trauma- and Stressor-Related Disorder] cause you any problems in your relationships with your family, romantic partner or friends?)*

*How did (SXS of Trauma- and Stressor-Related Disorder) affect your school/work? (How about your attendance at work or school? Did [SXS of Trauma- and Stressor-Related Disorder] make it more difficult to do your work/schoolwork? How did [SXS of Trauma- and Stressor-Related Disorder] affect the quality of your work/schoolwork?)*

*How did (SXS of Trauma- and Stressor-Related Disorder) affect your ability to take care of things at home? How about doing other things that are important to you like religious activities, physical exercise, or hobbies? Did you avoid doing anything because you felt like you weren’t up to it?*

*Did your (SXS of Trauma- and Stressor-Related Disorder) affect any other important part of your life?*

*If have not interfered with life: How much were you bothered or upset by having (SXS of Trauma- and Stressor-Related Disorder)?*

*If unclear: During the past month, have you had (SXS of Trauma- and Stressor-Related Disorder)? Check here ___ if present in last month.*

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= inadequate information  
1 = absent or false  
2 = subthreshold  
3 = threshold or true

---
Indicate type of Other Specified Trauma- and Stressor-related Disorder:
(circle the appropriate number)

1 – Adjustment-like disorders with delayed onset of symptoms that occur more than 3 months after the stressor.

2 – Adjustment-like disorders with prolonged duration of more than 6 months without prolonged duration of stressor.

3 – Persistent complex bereavement disorder: This disorder is characterized by severe and persistent grief and mourning reactions.

4 – Other: ________________________________

= inadequate information    1 = absent or false    2 = subthreshold    3 = threshold or true

END OF SCID
SEPARATION ANXIETY DISORDER (OPTIONAL) (CURRENT ONLY)*

IF SCREENING QUESTION #7a IS ANSWERED "NO," SKIP TO *OTHER SPECIFIED ANXIETY DISORDER* F.31.

IF QUESTION #7a ANSWERED "YES": You've said that in the past 6 months, since (6 MONTHS AGO), you have been especially anxious about being separated from people you're attached to, like your parents, children, or partner.

IF SCREENER NOT USED: In the past 6 months, since (6 MONTHS AGO), have you been especially anxious about being separated from people you're attached to (like your parents, children, or partner)?

Tell me about that.

IF NO: SKIP TO *OTHER SPECIFIED ANXIETY DISORDER* F.31.

Who are you most afraid of being separated from?

NOTE: REFER TO THESE MAJOR ATTACHMENT FIGURE(S) WHEN ASKING QUESTIONS BELOW.

In the past 6 months, since (6 MONTHS AGO), have you gotten upset when you've thought about being separated from (MAJOR ATTACHMENT FIGURE[S]) or being away from home? (How often?)

IF NO: How about when you actually were separated from (MAJOR ATTACHMENT FIGURE[S])? (How upset have you been? How often does this happen?)

...have you often worried a lot about something bad happening to (MAJOR ATTACHMENT FIGURE[S])?

IF YES: What sorts of things have you worried will happen to (MAJOR ATTACHMENT FIGURE[S])? (Why was that? Has anyone else worried about this?)

...have you often worried a lot about something bad happening to you that would separate you from (MAJOR ATTACHMENT FIGURE[S])?

IF YES: What sorts of things have you worried will happen to you? (Why was that? How worried have you been? Has anyone else worried about this?)

1. Recurrent excessive distress when anticipating or experiencing separation from home or from major attachment figures.

2. Persistent and excessive worry about losing major attachment figures or about possible harm to them, such as illness, injury, disasters, or death.

3. Persistent and excessive worry about experiencing an untoward event (e.g., getting lost, being kidnapped, having an accident, becoming ill) that causes separation from a major attachment figure.

|= inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true
SCID-RV (for DSM-5®) (Version 1.0.0)

**Separation Anxiety Disorder**

4. Persistent reluctance or refusal to go out, away from home, to school, to work, or elsewhere because of fear of separation.

   - **If Yes:** Why is that? (Is this due to your fear of being away from [MAJOR ATTACHMENT FIGURE(S)], or away from your home because it feels like a safe place?)

   - **If No:** Have you often found it difficult or even refused to go to school, work, or other places away from home?

      - **If Yes:** Why is that? (Is this due to your fear of being away from [MAJOR ATTACHMENT FIGURE(S)], or away from your home because it feels like a safe place?)

   - **If No:** Have you often felt anxious or afraid to be alone or without [MAJOR ATTACHMENT FIGURE(S)] even when you were at home?

      - **If No:** When you go with [MAJOR ATTACHMENT FIGURE(S)] to another place, have you usually felt anxious or afraid to be separated from them?

   - **If Yes:** Have you often found it difficult or impossible to sleep away from home? (Have you refused to sleep over at friends’ or relatives’ houses? Has it been difficult for you to travel without [MAJOR ATTACHMENT FIGURE(S)] coming along?)

      - **If No:** Have you often found it difficult to actually go to sleep without being near [MAJOR ATTACHMENT FIGURE(S)]? (Have you often insisted that [MAJOR ATTACHMENT FIGURE(S)] stay with you until you fell asleep?)

   - **If Yes:** Have you had nightmares about being separated from [MAJOR ATTACHMENT FIGURE(S)]? Tell me about them. (Have you had nightmares about things like you or [MAJOR ATTACHMENT FIGURE(S)] getting lost, injured, or kidnapped, or not being able to make it back home?)

      - **If Yes:** How often?

   - **If No:** Have you felt physically sick, like having headaches, stomachaches, dizziness, heart racing, or fainting when you were separated from [MAJOR ATTACHMENT FIGURE(S)]?

      - **If Yes:** How often does this happen?

      - **If No:** How about feeling sick when you thought about being separated from [MAJOR ATTACHMENT FIGURE(S)]? (How often does this happen?)

? = inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true
How long has your anxiety or fear of being separated gone on?

IF UNKNOWN: Has it lasted for at least 6 months or more?

IF UNKNOWN: What effect have (SEPARATION ANXIETY SXS) had on your life during the past 6 months, since (6 MONTHS AGO)?

ASK THE FOLLOWING QUESTIONS AS NEEDED TO RATE CRITERION C:

How have (SEPARATION ANXIETY SXS) affected your relationships or your interactions with other people? (Have [SEPARATION ANXIETY SXS] caused any problems in your relationships with your family, romantic partner or friends?)

How have (SEPARATION ANXIETY SXS) affected your work/schoolwork? (How about your attendance at work or school? Did [SEPARATION ANXIETY SXS] make it more difficult to do your work/schoolwork? How have [SEPARATION ANXIETY SXS] affected the quality of your work/schoolwork?)

How have (SEPARATION ANXIETY SXS) affected your ability to take care of your family or household needs, or be involved in things that are important to you like religious activities, physical exercise, or hobbies?

Have (SEPARATION ANXIETY SXS) affected any other important part of your life?

IF SXS HAVE NOT INTERFERED WITH FUNCTIONING: How much have you been bothered or upset by having (SEPARATION ANXIETY SXS)?
D. The disturbance is not better explained by another mental disorder, such as refusing to leave home because of excessive resistance to change in Autism Spectrum Disorder, delusions or hallucinations concerning separation in Psychotic Disorders, refusal to go outside without a trusted companion in Agoraphobia, worries about ill health or other harm befalling significant others in Generalized Anxiety Disorder; or concerns about having an illness in Illness Anxiety Disorder.

**SEPARATION ANXIETY DISORDER CRITERIA A, B, C, AND D ARE CODED “3.”**

**IF UNKNOWN:** How old were you when you first started having (SXS OF SEPARATION ANXIETY DISORDER)?

Age at onset of Separation Anxiety Disorder (CODE 99 IF UNKNOWN).

Specify if:

**IF UNKNOWN:** Have you had any panic attacks in the past month?

___ With panic attacks: if one or more panic attacks in the past month occurring in the context of current Separation Anxiety Disorder (see page F.7) and criteria have never been met for Panic Disorder.
*HOARDING DISORDER  HOARDING DISORDER CRITERIA  (OPTIONAL)*

**SCREENING QUESTION #11a**

IF SCREENING QUESTION #11a IS ANSWERED "NO," GO TO *BODY DYSMORPHIC DISORDER* Opt-G.6.

IF QUESTION #11a ANSWERED "YES":

**YOU'VE SAID THAT YOU HAVE FOUND IT DIFFICULT TO THROW OUT, SELL, OR GIVE AWAY THINGS.**

IF SCREENER NOT USED:

Have you found it difficult to throw out, sell, or give away things?

Tell me about that. (What kinds of things do you find it most difficult to get rid of? Do you find it hard to get rid of things that most other people would have no problem getting rid of? Things like newspapers, magazines, old clothing, bags, books, mail, and paperwork?)

A. Persistent difficulty discarding or parting with possessions, regardless of their actual value.

**SCREEN Q#11a**

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**IF NO:**

GO TO *BODY DYSMORPHIC DISORDER* Opt-G.6

How long has this been going on?

What makes it so difficult to get rid of these things? (Is it because you feel like you need to save them for some purpose?)

B. This difficulty is due to a perceived need to save the items and to distress associated with discarding them.

**GO TO *BODY DYSMORPHIC DISORDER* Opt-G.6**

Have you gotten upset when you or other people have tried to get rid of your stuff?

**IF NEVER TRIED:**

Do you think that you would get very upset if you or other people tried to get rid of your stuff?

**GO TO *BODY DYSMORPHIC DISORDER* Opt-G.6**

Are your rooms so crowded with your stuff that you can't get to parts of them or use them the way they are meant to be used? (For example, not being able to prepare food in your kitchen because the counters are covered with your stuff?)

C. The difficulty discarding possessions results in the accumulation of possessions that congest and clutter active living areas and substantially compromises their intended use. If living areas are uncluttered, it is only because of the interventions of third parties (e.g., family members, cleaners, authorities).

**GO TO *BODY DYSMORPHIC DISORDER* Opt-G.6**

? = inadequate information  1 = absent or false  2 = subthreshold  3 = threshold or true
IF UNKNOWN: What effect have (HOARDING SXS) had on your life?

ASK THE FOLLOWING QUESTIONS AS NEEDED TO RATE CRITERION D:

How have (HOARDING SXS) affected your relationships or your interactions with other people? (Have [HOARDING SXS] led to problems with other people? With family members? Roommates? Your landlord? Neighbors? Co-workers?)

How have (HOARDING SXS) affected your work/school? (Have [HOARDING SXS] made it hard for you to do a good job at work or at school? For example, by making it very difficult or time-consuming to find things you need?)

How have (HOARDING SXS) affected your ability to take care of things at home?

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?)

Has anyone ever told you that your living area is a health or fire hazard because you have too much stuff?

IF NO: Do you think if someone saw your living area, they would think that it is a fire or health hazard?

Have (HOARDING SXS) affected any other important part of your life?

IF HAS NOT INTERFERED WITH LIFE: How much has it bothered or upset you that you have difficulty getting rid of stuff or that your place is cluttered?

D. The hoarding causes clinically significant distress or impairment in social, occupational, or other important areas of functioning (including maintaining a safe environment for self and others).

GO TO *BODY DYSMORPHIC DISORDER* Opt-G.6

? = inadequate information  1 = absent or false  2 = subthreshold  3 = threshold or true
**SCID-RV (for DSM-5®) (Version 1.0.0)  Hoarding Disorder  Opt. OC-Related Disorder  Opt-G.3**

**IF UNKNOWN: When did (HOARDING SXS) begin?**

Just before it began, were you physically ill? (What did the doctor say?)

- **E.** [Primary Hoarding Disorder: ] The hoarding is not attributable to another medical condition (e.g., brain injury, cerebrovascular disease, Prader-Willi syndrome).

  - **IF THERE IS ANY INDICATION THAT THE SYMPTOMS OF HOARDING MAY BE SECONDARY (I.E., A DIRECT PHYSIOLOGICAL CONSEQUENCE OF GMC), GO TO *GMC/SUBSTANCE* G.11, AND RETURN HERE TO MAKE A RATING OF "1" OR "3."**

  - Etiological medical conditions include: traumatic brain injury, surgical resection for treatment of a tumor or seizure control, cerebrovascular disease, infections of the central nervous system (e.g., herpes simplex encephalitis), or Prader-Willi syndrome.

F. The hoarding is not better explained by the symptoms of another mental disorder (e.g., obsessions in Obsessive-Compulsive Disorder, decreased energy in Major Depressive Disorder, delusions in Schizophrenia or another psychotic disorder, cognitive deficits in Major Neurocognitive Disorder, restricted interests in Autism Spectrum Disorder).

- **HOARDING DISORDER CRITERIA A, B, C, D, E, AND F ARE CODED “3.”**

**HOARDING DISORDER CHRONOLOGY**

**NOTE: IF LIFETIME ASSESSMENT ALREADY SUGGESTS THE PRESENCE OF HOARDING DISORDER DURING THE PAST MONTH, ASK THE FOLLOWING QUESTIONS ONLY IF NEEDED.**

In the past month, since (1 MONTH AGO), have you continued to find it difficult to throw out, sell or give away things?

In the past month, have your rooms been so crowded with your stuff that you couldn’t get to parts of them or use them the way they were meant to be used? (For example, not being able to prepare food in your kitchen because the counters were covered with your stuff?)

**IF NO: Is that only because family members or other people got rid of your stuff?**

- **A.** [During the past month,] persistent difficulty discarding or parting with possessions, regardless of their actual value.

- **B.** [During the past month,] the difficulty discarding possessions results in the accumulation of possessions that congest and clutter active living areas and substantially compromises their intended use. If living areas are uncluttered, it is only because of the interventions of third parties (e.g., family members, cleaners, authorities).

- **C.** [During the past month,] the difficulty discarding possessions results in the accumulation of possessions that congest and clutter active living areas and substantially compromises their intended use. If living areas are uncluttered, it is only because of the interventions of third parties (e.g., family members, cleaners, authorities).

- **DUE TO GMC GO TO *BODY DYSMORPHIC DISORDER* Opt-G.6**

- **CONTINUE WITH NEXT ITEM**

- **GO TO *BODY DYSMORPHIC DISORDER* Opt-G.6**

- **CONTINUE WITH NEXT ITEM**

- **GO TO *PAST HOARDING DISORDER* Opt-G.5**

- **CONTINUE WITH NEXT ITEM**

- **GO TO *PAST HOARDING DISORDER* Opt-G.5**

?=inadequate information 1=absent or false 2=subthreshold 3=threshold or true
In the past month, since (1 MONTH AGO), what effect have (HOARDING SXS) had on your life?

IF DOES NOT INTERFERE WITH LIFE: In the past month, how much has it bothered or upset you that you have difficulty getting rid of stuff or that your place is cluttered?

IF UNKNOWN: How old were you when you first started having (SXS OF HOARDING DISORDER)?

Tell me about how you get most of your stuff.

(Do you buy a lot of things even though you don’t need them or have space for them?)

(Do you often pick up free things, for example, discarded items or get things from friends or other people even though you don’t need them or have space for them?)

(How about taking samples from hotel rooms or restaurants or extra supplies from your workplace or school?)

(Do you sometimes take things without paying for them, even though you don’t need them or have space for them?)

On average, over the past week, how much has your difficulty throwing things out, or your acquiring a lot of things, caused problems for you or other people? Tell me about that.

IF DENIES PROBLEMS: What about (CLUTTERED LIVING AREAS)? (Does it make it difficult to get around?)

Specify current level of **insight** (i.e., during the past week): (circle the appropriate number)

1 – **With good or fair insight:** The individual recognizes that hoarding-related beliefs and behaviors (pertaining to difficulty discarding items, clutter, or excessive acquisition) are problematic.

2 – **With poor insight:** The individual is mostly convinced that hoarding-related beliefs and behaviors (pertaining to difficulty discarding items, clutter, or excessive acquisition) are not problematic despite evidence to the contrary.

3 – **With absent insight/delusional beliefs:** The individual is completely convinced that hoarding-related beliefs and behaviors (pertaining to difficulty discarding items, clutter, or excessive acquisition) are not problematic despite evidence to the contrary.

?=inadequate information 1=absent or false 2=subthreshold 3=threshold or true
SCID-RV (for DSM-5®) (Version 1.0.0) 

Hoarding Disorder 
Opt. OC-Related Disorder 
Opt-G.5

Specify if:

IF UNKNOWN: Have you had any panic attacks in the past month? 

___ With panic attacks: If one or more panic attacks in the past month occurring in the context of current Hoarding Disorder (see page F.7) and criteria have never been met for Panic Disorder.

*PAST HOARDING DISORDER*

When did you last have (ANY SXS OF HOARDING DISORDER)?

Number of months prior to interview when last had a symptom of Hoarding Disorder ____ ____ ____

IF UNKNOWN: How old were you when you first started having (SXS OF HOARDING DISORDER)?

Age at onset of Hoarding Disorder (CODE 99 IF UNKNOWN) ____ ____

GO TO *BODY DYSMORPHIC DISORDER* 
Opt-G.6

?=inadequate information 
1=absent or false 
2=subthreshold 
3=threshold or true
**BODY DYSMORPHIC DISORDER (OPTIONAL)**

IF SCREENING QUESTION #11b ANSWERED "NO," SKIP TO
*TRICHOTILLOMANIA* Opt-G.10

IF QUESTION #11b ANSWERED "YES":
You’ve said that you have been very concerned that there was something wrong with your physical appearance or the way 1 or more parts of your body looks. What have you thought was wrong with (your appearance/BODY PART)? (Can you show it to me or describe it to me? Have other people noticed it? What have they said?)

IF SCREENER NOT USED: Have you been very concerned that there was something wrong with your physical appearance or the way 1 or more parts of your body looks?

IF YES: Tell me about your concern. (What have you thought was wrong with [your appearance/BODY PART]? Can you show it to me or describe it to me? Have other people noticed it? What have they said?)

How much of the time have you thought about (DEFECT OR FLAW)? (Have you thought about it more than you should?)

Have you ever spent a lot of time comparing the way your (BODY PART) looked to the way other people’s (BODY PART) looked?

How about spending a lot of time doing things like repeatedly checking in mirrors to see how (BODY PART) looks or spending a lot of time trying to fix it or cover it up? (Things like...covering it up with make-up, clothing or the way your wear your hair? How about pulling out your hair or picking your skin? Seeking cosmetic procedures? Vigorous exercise or weight lifting?)

How about asking others whether they think your (BODY PART) looks ugly or defective?

IF YES TO ANY: How often?

A. Preoccupation with one or more perceived defects or flaws in physical appearance that are not observable or appear slight to others.

NOTE: Code "3" only if not clearly visible at conversational distance or not noticeable unless subject points it out.

B. At some point during the course of the disorder, the individual has performed repetitive behaviors (e.g., mirror checking, excessive grooming, skin picking, reassurance seeking) or mental acts (e.g., comparing his or her appearance with that of others) in response to the appearance concerns.
IF UNKNOWN: What effect have (BDD SXS) C. The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

ASK THE FOLLOWING QUESTIONS AS NEEDED TO RATE CRITERION C:

How have (BDD SXS) affected your relationships or your interactions with other people? (Have [BDD SXS] caused you any problems in your relationships with your family, romantic partner or friends? Have you avoided intimate relationships because of [BDD SXS]?)

How have your concerns with the way you look affected your work/school? (How about your attendance at work or school? Has the amount of time you spent thinking about it or dealing with it made it hard for you to do your job/schoolwork?)

How have your concerns with the way you look affected your ability to take care of things at home? How about doing other things that are important to you, like religious activities, physical exercise, or hobbies? Have you avoided places or situations because of your concerns about the way your body looks?

Have your concerns with the way you look affected any other important part of your life?

IF DOES NOT INTERFERE WITH LIFE: How much have you been bothered or upset about your concerns about the way you look?

IF AN EATING DISORDER SEEMS LIKELY AND IF ANSWER IS NOT KNOWN: Have your concerns about (BODY PART) beyond just thinking that it looked fat or flabby?

D. The preoccupation is not better explained by concerns with body fat or weight in an individual whose symptoms meet diagnostic criteria for an Eating Disorder.

CRITERIA A, B, C, AND D ARE CODED “3.”
**BODY DYSMORPHIC DISORDER CHRONOLOGY**

A. [During the past month,] preoccupation with one or more perceived defects or flaws in physical appearance that are not observable or appear slight to others.

B. In the past month, since (1 MONTH AGO), have you been very concerned with the way (BODY PART[S] MENTIONED ABOVE) look?

C. [During the past month,] the preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

IF DOES NOT INTERFERE WITH LIFE: In the past month, how much have your been bothered or upset about your concerns about the way you look?

**CURRENT BODY DYSMORPHIC DISORDER**

IF UNKNOWN: How old were you when you first started having serious concerns about that way you look? (CODE 99 IF UNKNOWN).

What word would you use to describe all of the parts of your body that you do not like? (Deformed? Ugly?)

Over the past week (on average), to what extent did you think that this is true? (Are you completely convinced?)

Specify degree of insight regarding Body Dysmorphic Disorder beliefs (e.g., “I look ugly” or “I look deformed”) in the past week: (circle the appropriate number)

1 – With good or fair insight: The individual recognizes that the Body Dysmorphic Disorder beliefs are definitely or probably not true or that they may or may not be true.

2 – With poor insight: The individual thinks that the Body Dysmorphic Disorder beliefs are probably true.

3 – With absent insight/delusional beliefs: The individual is completely convinced that Body Dysmorphic Disorder beliefs are true.

IF UNKNOWN: Are you very concerned about your body build or how muscular you are?

IF YES: How much time do you spend thinking about it? How much time do you spend going to the gym to work out? Have these concerns about your body build or muscularity upset you a lot or caused problems for you?

Specify if:

OC30 – 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.
*PAST BODY DYSMORPHIC DISORDER*

When did you last have (ANY SXS OF BDD)?

Number of months prior to interview when last had a symptom of Body Dysmorphic Disorder  ____  ____  ____  OG32

IF UNKNOWN: How old were you when you first started having (SXS OF BDD)?

Age at onset of Body Dysmorphic Disorder (CODE 99 IF UNKNOWN)  ____  ____  OG33

GO TO *TRICHO-TILLOMANIA* Opt-G.10
**TRICHTILLOMANIA (HAIR-PULLING DISORDER) (OPTIONAL)**

**IF SCREENING QUESTION #11c ANSWERED “NO”, SKIP TO **


**IF QUESTION #11c ANSWERED “YES”: You’ve said that you’ve repeatedly pulled out hair from somewhere on your body other than for cosmetic reasons. Tell me about that. (How often?)**

**IF SCREENER NOT USED:** Have you ever repeatedly pulled out hair from anywhere on your body other than for cosmetic reasons?

Tell me about that. (How often?)

Have you tried to cut down or stop pulling out your hair?

**IF YES:** How many times?

What effect has your hair-pulling had on your life?

**ASK THE FOLLOWING QUESTIONS AS NEEDED TO RATE CRITERION C:**

How has your hair-pulling affected your relationships or your interactions with other people? (Has it caused you any problems in your relationships with your family, romantic partner or friends?)

How has your hair-pulling affected your work/school? (Have you had trouble concentrating on things like work or school because of it?)

How has your hair-pulling affected your ability to take care of things at home? What about being involved in things that are important to you like religious activities, physical exercise, or hobbies?

Have you avoided situations or people because you didn’t want to be seen pulling out your hair or because you were embarrassed by its effects? Has your hair-pulling affected any other important part of your life?

**IF HAS NOT INTERFERED WITH LIFE:** How much have you been bothered or upset by your hair-pulling?

? = inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true
SCID-RV (for DSM-5®) (Version 1.0.0)  

**Trichotillomania**  

**Opt. OC-Related Disorder**  

**Opt-G.11**  

**IF UNKNOWN:** Did you have a medical condition or skin problem that caused your hair loss? (Tell me about that.)  

D. The hair-pulling or hair loss is not attributable to another medical condition (e.g., a dermatological condition).  

IF CURRENT OR PAST HX OF BODY DYSMORPHIC DISORDER: Would you say that most of your hair pulling is done to fix a specific flaw or defect in your appearance?  

E. The hair-pulling is not better explained by the symptoms of another mental disorder (e.g., attempts to improve a perceived defect or flaw in appearance in Body Dysmorphic Disorder).  

**CRITERIA A, B, C, D, AND E ARE CODED “3”**  

**IF UNKNOWN:** Did you have a medical condition or skin problem that caused your hair loss? (Tell me about that.)  

D. The hair-pulling or hair loss is not attributable to another medical condition (e.g., a dermatological condition).  

IF CURRENT OR PAST HX OF BODY DYSMORPHIC DISORDER: Would you say that most of your hair pulling is done to fix a specific flaw or defect in your appearance?  

E. The hair-pulling is not better explained by the symptoms of another mental disorder (e.g., attempts to improve a perceived defect or flaw in appearance in Body Dysmorphic Disorder).  

CRITERIA A, B, C, D, AND E ARE CODED “3”  

**TRICHOTILLOMANIA CHRONOLOGY**  

NOTE: IF LIFETIME ASSESSMENT ALREADY SUGGESTS THE PRESENCE OF TRICHOTILLOMANIA DURING THE PAST MONTH, ASK THE FOLLOWING QUESTIONS ONLY IF NEEDED.  

In the past month, since (1 MONTH AGO), have you repeatedly pulled out hair from anywhere on your body?  

In the past month, have you tried to cut down or stop pulling out your hair?  

IF YES: How many times?  

In the past month, since (1 MONTH AGO), what effect has your hair-pulling had on your life?  

IF DOES NOT INTERFERE WITH LIFE: In the past month, how much have you been bothered or upset by your hair-pulling?  

**? = inadequate information**  

**1 = absent or false**  

**2 = subthreshold**  

**3 = threshold or true**
*CURRENT TRICHOTILLOMANIA*

CRITERIA A, B, AND C CODED “3” IN PAST MONTH

1  3

1

GO TO *PAST TRICHOTILLOMANIA*

CURRENT TRICHOTILLOMANIA

IF UNKNOWN: How old were you when you first started pulling out your hair to the point where it was a problem for you?

Age at onset of Trichotillomania (CODE 99 IF UNKNOWN).

OG44

*PAST TRICHOTILLOMANIA*

When did you last have (ANY SXS OF TRICHOTILLOMANIA)?

Number of months prior to interview when last had a symptom of Trichotillomania.

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OG46

IF UNKNOWN: How old were you when you first started pulling your hair to the point where it was a problem for you?

Age at onset of Trichotillomania (CODE 99 IF UNKNOWN).

OG47

GO TO *EXCORIATION DISORDER* Opt-G.13

?=inadequate information  1=absent or false  2=subthreshold  3=threshold or true

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**EXCORIATION (SKIN-PICKING) DISORDER (OPTIONAL)**

*EXCORIATION (SKIN-PICKING) DISORDER CRITERIA*

IF SCREENING QUESTION #11d ANSWERED "NO," SKIP TO *OTHER SPECIFIED OC AND RELATED DISORDER* G.8

IF QUESTION #11d ANSWERED "YES": You’ve said that you’ve repeatedly picked at your skin with your fingernails, tweezers, pins, or other objects. Which area or areas of your skin do you pick?

IF SCREENER NOT USED: Have you ever repeatedly picked at your skin with your fingernails, tweezers, pins, or other objects?

IF YES: Which area or areas of your skin do you pick?

Did the picking create noticeable damage to your skin or lead to scratches, sores, scabs, or infection?

Have you tried to cut down or stop picking at your skin?

IF YES: How many times?

IF UNKNOWN: What effect did your skin-picking have on your life?

ASK THE FOLLOWING QUESTIONS AS NEEDED TO RATE CRITERION C:

How has your skin-picking affected your relationships or your interactions with other people? (Has it caused you any problems in your relationships with your family, romantic partner or friends?)

How has your skin-picking affected your work/school? (Have you had trouble concentrating on things like work or school because of it?)

How has your skin-picking affected your ability to take care of things at home? What about being involved in things that are important to you like religious activities, physical exercise, or hobbies? Have you avoided situations or people because you didn’t want to be seen picking your skin or because you were embarrassed by its effects?

Has your skin-picking affected any other important part of your life?

IF HAS NOT INTERFERED WITH LIFE: How much have you been bothered or upset by your skin picking?

?=inadequate information    1=absent or false    2=subthreshold    3=threshold or true
SCID-RV (for DSM-5®) (Version 1.0.0)  

**Excoriation Disorder**  

**Opt. OC-Related Disorders**  

**Opt-G.14**

**IF UNKNOWN:** Did you have a medical condition or skin problem that caused you to pick your skin? (What is that? Do you still have that medical condition?)

**IF THE MEDICAL CONDITION HAS RESOLVED:** Do you still pick your skin?

Do you pick your skin only when you are taking drugs or medicines? (Tell me about that.)

D. [Primary Excoriation Disorder:] The skin picking is not attributable to the physiological effects of a substance (e.g., cocaine) or another medical condition (e.g., scabies).

IF THERE IS ANY INDICATION THAT THE SKIN PICKING MAY BE SECONDARY (I.E., A DIRECT PHYSIOLOGICAL CONSEQUENCE OF GMC OR SUBSTANCE), GO TO *GMC/SUBSTANCE* G.11 AND RETURN HERE TO MAKE A RATING OF “1” OR “3.”

Etiological medical conditions include: dermatological conditions such as scabies or acne

Etiological substances include: stimulants

E. The skin picking is not better explained by the symptoms of 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, or stereotypies in Stereotypic Movement Disorder.

CRITERIA A, B, C, D, AND E ARE CODED “3.”

***EXCORIATION DISORDER CHRONOLOGY***

NOTE: IF LIFETIME ASSESSMENT ALREADY SUGGESTS THE PRESENCE OF EXCORIATION DISORDER DURING THE PAST MONTH, ASK THE FOLLOWING QUESTIONS ONLY IF NEEDED.

In the past month, since (1 MONTH AGO), have you repeatedly picked at your skin with your fingernails, tweezers, pins, or other objects?

**IF YES:** Did the picking create noticeable damage to your skin or lead to scratches, sores, scabs or infection?

In the past month, have you tried to cut down or stop picking at your skin?

**IF YES:** How many times?

A. [During the past month,] recurrent skin picking resulting in skin lesions.

B. [During the past month,] repeated attempts to decrease or stop skin picking.

**? = inadequate information**  

1 = absent or false  

2 = subthreshold  

3 = threshold or true

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**SCID-RV (for DSM-5®) (Version 1.0.0)**

**Excoriation Disorder**

In the past month, since (1 MONTH AGO), what effect did your skin-picking have on your life?

*IF DOES NOT INTERFERE WITH LIFE*: In the past month, how much have you been bothered or upset by your skin picking?

**CURRENT EXCORIATION DISORDER***

C. [During the past month,] The skin picking causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

**PAST EXCORIATION DISORDER***

IF UNKNOWN: How old were you when you first started picking your skin to the point where it was a problem for you?

**CURRENT EXCORIATION DISORDER***

CRITERIA A, B, AND C CODED “3” IN THE PAST MONTH

**IF UNKNOWN**: How old were you when you first started picking your skin to the point where it was a problem for you?

**PAST EXCORIATION DISORDER***

When did you last have (ANY SXS OF EXCORIATION DISORDER)?

**Current Excoriation Disorder***

Go to *Current Excoriation Disorder*

Opt-G.15

**Past Excoriation Disorder***

Go to *Past Excoriation Disorder*

Opt-G.15

**Current Excoriation Disorder***

Go to *Current Excoriation Disorder*

Opt-G.15

**Past Excoriation Disorder***

Go to *Past Excoriation Disorder*

Opt-G.15

?= inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true
H. SLEEP-WAKE DISORDERS (OPTIONAL)

*INSOMNIA DISORDER (OPTIONAL) (CURRENT ONLY)*

1. IF SCREENING QUESTION #11e ANSWERED "NO," SKIP TO "HYPERSOMNOLENCE DISORDER" Opt-H.5.

2. IF SCREENING QUESTION #11e ANSWERED "YES":
   You’ve said that over the past 3 months, since (3 MONTHS AGO), a major concern of yours has been that you are not getting enough good sleep or not feeling rested. Tell me about that. (How often?)

3. IF SCREENER NOT USED: Over the past 3 months, since (3 MONTHS AGO), has a major concern of yours been that you are not getting enough good sleep or not feeling rested? Tell me about that. (How often?)

Let me ask you some more about your trouble sleeping. During the past 3 months, since (3 MONTHS AGO), what time have you usually gone to sleep? What time have you usually woken up for the last time each morning?

Have you had trouble falling asleep? (How long has it been taking you to fall asleep? At least 30 minutes?)

Once you’ve gotten to sleep, have you woken up frequently in the middle of the night? (Is it only because you had to get up often to use the bathroom? When you woke up, how long did you stay awake for...at least 30 minutes?)

   IF NO: How about having a lot of trouble falling back to sleep again after waking up during the night?

Is the time you are regularly waking up earlier than you have to wake up? (Why do you think you are waking up so early? How much earlier? Is it at least 30 minutes earlier?)

   IF YES: Are you not able to go back to sleep?

A. A predominant complaint of dissatisfaction with sleep quantity or quality...

...associated with one (or more) of the following symptoms:

1. Difficulty initiating sleep.

2. Difficulty maintaining sleep, characterized by frequent awakenings or problems returning to sleep after awakenings.

3. Early-morning awakening with inability to return to sleep

NOTE: Do not code "3" if awakenings are due to reasons other than insomnia (e.g., frequent toilet use).

NOTE: Consider average total sleep time. Code "3" only if less than 6 1/2 hours.

AT LEAST ONE "A" SYMPTOM CODED "3."

? = inadequate information  
1 = absent or false  
2 = subthreshold  
3 = threshold or true
IF UNKNOWN: What effect have your sleeping problems had on your life during the past 3 months, since (3 MONTHS AGO)?

ASK THE FOLLOWING QUESTIONS AS NEEDED TO RATE CRITERION B:

How have they affected your relationships or your interactions with other people? (Have they caused you any problems in your relationships with your family, romantic partner or friends?)

How have your sleeping problems affected your work/school? (Have they affected the quality of your work/schoolwork? Have you missed work or school or had problems at work or school because of your not getting enough sleep?)

How have they affected your ability to take care of things at home? What about being involved in things that are important to you, like religious activities, physical exercise, or hobbies? (Have you been irritable during the day because you've been unable to get enough sleep?)

Have you felt unsafe to drive or “fallen asleep at the wheel” because of your not getting enough sleep? How about it being unsafe for you to do other things that might be dangerous, like operating heavy machinery?

Have your sleeping problems affected any other important part of your life?

IF DOES NOT INTERFERE WITH LIFE: How much have you been bothered or upset by your sleeping problems?

How many nights a week, on average, have you had difficulty sleeping? (At least 3 nights a week for the past 3 months?)

C/D. The sleep difficulty occurs at least 3 nights per week and has been present for at least 3 months.

NOTE: Criterion C and criterion D have been combined.

IF UNCLEAR: Is there anything stopping you from getting enough sleep? (Things like too much noise or light, too hot or too cold, uncomfortable bedding, or not enough time in your schedule?)

E. The sleep difficulty occurs despite adequate opportunity for sleep.

NOTE: Criterion F has intentionally been placed at the end of the Insomnia Disorder criteria.

? = inadequate information  1 = absent or false  2 = subthreshold  3 = threshold or true
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IF UNKNOWN: When did your sleep problems begin?

Just before this began, were you using any medications?
IF YES: Any change in the amount you were using?

Just before this began, were you drinking or using any drugs?

How much coffee, tea, energy drinks, or other caffeine-containing drinks, sodas, or pills do you consume?

IF THERE IS ANY INDICATION THAT INSOMNIA MAY BE A DIRECT PHYSIOLOGICAL CONSEQUENCE OF A SUBSTANCE/MEDICATION, GO TO *SUBSTANCE-INDUCED* Opt-H.9, AND RETURN HERE TO MAKE A RATING OF “1” OR “3.”

Etiological substances/medications include: alcohol (I/W); caffeine (I/W); cannabis (I/W); opioids (I/W); sedatives, hypnotics, or anxiolytics (I/W); stimulants (including cocaine) (I/W), tobacco (W), adrenergic agonists and antagonists, dopamine agonists and antagonists, cholinergic agonists and antagonists, serotonergic agonists and antagonists, antihistamines, and corticosteroids.

IF CO-OCcurring MENTAL DISORDER OR GENERAL MEDICAL CONDITION: Did your problems sleeping begin before (MENTAL DISORDER OR MEDICAL CONDITION)?

H. Coexisting mental disorders and medical conditions do not adequately explain the predominant complaint of insomnia.

NOTE: Code “3” if no co-existing mental disorders or medical conditions or, if co-existing disorders, they do not adequately explain the insomnia.

IF UNKNOWN: Have you seen a doctor for this problem? (Have you stayed overnight at a sleep laboratory?)

IF YES: What did the doctor say was the diagnosis?

I. The insomnia is not better explained by and does not occur exclusively during the course of another Sleep-Wake Disorder (e.g., Narcolepsy, a Breathing-Related Sleep Disorder, a Circadian Rhythm Sleep-Disorder, a Parasomnia).

NOTE: Code “?” if co-existing sleep disorder has not yet been ruled out. Code “3” only if no co-existing sleep disorder or, if there is a co-existing sleep disorder, it does not adequately explain the insomnia.

CRITERIA A, B, C, D, E, G, AND H ARE CODED “3”

NOTE: Whether there is a “?” rated for Criterion F determines whether the diagnosis of Insomnia Disorder is Definite vs. Provisional. See below.

Indicate whether provisional vs. definite diagnosis: (circle the appropriate number)

1 – Provisional dx: criterion F is rated “?,” i.e., a co-existing Sleep-wake Disorder has not been ruled out).

2 – Definite dx: criterion F is rated “1” or “3,” i.e., a co-existing Sleep-Wake Disorder has been either ruled in (criterion F rated “3”) or ruled out (criterion F rated “1”).

?=inadequate information  1=absent or false  2=subthreshold  3=threshold or true
Specify **associated conditions**: (check all that apply)

___ With non-sleep disorder mental comorbidity
   List comorbid mental disorder(s): __________________________

___ With other medical comorbidity
   List comorbid medical condition(s): __________________________

___ With other sleep disorders
   List comorbid sleep disorder(s): __________________________

**IF UNKNOWN:** Have you had more than one episode of difficulty sleeping in the past year?

Specify **course**:

___ **Recurrent**: Two (or more) episodes within the space of one year
HYPERSOMNOLENCE DISORDER (OPTIONAL) (CURRENT ONLY)

**IF SCREENING QUESTION #11f ANSWERED “NO,” SKIP TO NEXT MODULE.**

**IF SCREENING QUESTION #11f ANSWERED “YES”:**
You’ve said that over the past 3 months, since (3 MONTHS AGO), you have often had days when you were sleepy despite having slept for at least 7 hours. Tell me about that. (How often?)

**IF SCREENER NOT USED:** Over the past 3 months, since (3 MONTHS AGO), have you often had days when you were sleepy despite having slept for at least 7 hours? Tell me about that. (How often?)

**IF UNKNOWN:** What time do you usually go to sleep? What time do you usually wake up for the last time each morning?

During those days when you were sleepy...

...were you so sleepy that you repeatedly fell asleep or “nodded off” when you didn’t want to?

...did you get at least nine hours of sleep, and still wake up feeling tired?

...have you or a family member or bed partner noticed that when you are suddenly awakened, you have trouble fully waking up? For example, right when waking up from a nap, have you been confused, not known where you are, groggy or clumsy? What about striking out at the person who is trying to wake you?

**CRITERION A.1, A.2, OR A.3 IS CODED “3”**

B. The hypersomnolence occurs at least 3 times per week, for at least 3 months.

? = inadequate information

1 = absent or false

2 = subthreshold

3 = threshold or true
SCID-RV (for DSM-5®) (Version 1.0.0)

Hypersomnolence Disorder

Optional Sleep-Wake Opt-H.6

IF UNKNOWN: What effect has your sleepiness had on your life?

ASK THE FOLLOWING QUESTIONS AS NEEDED TO RATE CRITERION C:

How has it affected your relationships or your interactions with other people? (Have they caused you any problems in your relationships with your family, romantic partner or friends? Have you been irritable during the day because you’ve been so sleepy?)

How has your sleepiness affected your work/school? (Has it affected the quality of your work/schoolwork? Have you missed work or school or had problems at work or school because of your sleepiness? Have you had trouble thinking clearly because of your sleepiness?)

How has your sleepiness affected your ability to take care of things at home? What about being involved in things that are important to you like religious activities, physical exercise, or hobbies?

Have you felt unsafe to drive or “fallen asleep at the wheel” because of your being sleepy? How about it being unsafe for you to do other things that might be dangerous, like operating heavy machinery?

Has your sleepiness affected any other important part of your life?

IF DOES NOT INTERFERE WITH LIFE: How much have you been bothered or upset by your problems with sleepiness?

IF UNKNOWN: When did your problems with sleepiness begin?

Just before this began, were you using any medications?

IF YES: Any change in the amount you were using?

Just before this began, were you drinking or using any drugs?

C. The hypersomnolence is accompanied by significant distress or impairment in cognitive, social, occupational, or other important areas of functioning.

NOTE: Criterion D has intentionally been placed at the end of the Hypersomnolence Disorder criteria.

E. [Primary hypersomnolence:] The hypersomnolence is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication).

IF THERE IS ANY INDICATION THAT HYPERSOMNOLENCE MAY BE A DIRECT PHYSIOLOGICAL CONSEQUENCE OF A SUBSTANCE/MEDICATION, GO TO *SUBSTANCE-INDUCED* Opt-H.9, AND RETURN HERE TO MAKE A RATING OF “1” OR “3.”

NOTE: Refer to list of etiological substances/medications on page Opt-H.3.

?= inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true
SCID-RV (for DSM-5®) (Version 1.0.0)  Hypersomnolence Disorder  Optional Sleep-Wake  Opt-H.7

**IF CO-OCcurring MENTAL DISORDER OR GENERAL MEDICAL CONDITION:** Did your problems with sleepiness begin before (MENTAL DISORDER OR MEDICAL CONDITION)?

F. Coexisting mental disorders and medical conditions do not adequately explain the predominant complaint of hypersomnolence.

NOTE: Code "3" if no co-existing mental disorders or medical conditions or, if co-existing disorders, they do not adequately explain the hypersomnolence.

**IF UNKNOWN:** Have you seen a doctor for this problem? (Have you stayed overnight at a sleep laboratory?)

**IF YES:** What did the doctor say was wrong?

D. The hypersomnolence is not better explained by and does not occur exclusively during the course of another sleep-wake disorder (e.g., Narcolepsy, a Breathing-Related Sleep Disorder, a Circadian Rhythm Sleep-Wake Disorder, or a Parasomnia).

NOTE: Code "?” if co-existing sleep disorder has not yet been ruled out. Code “3” only if no co-existing sleep disorder or, if there is a co-existing sleep disorder, it does not adequately explain the hypersomnolence.

CRITERIA A, B, C, E, AND F ARE CODED “3”

NOTE: Whether there is a “?” rated for Criterion D determines whether the diagnosis of Hypersomnolence Disorder is Definite vs. Provisional. See below.

**Indicate whether **provisional vs. definitive:** (circle the appropriate number)

1 – **Provisional dx**: criterion D is rated “?,” i.e., a co-existing Sleep-wake Disorder has not been ruled out

2 – **Definite dx**: criterion D is rated “1” or “3,” i.e., a co-existing Sleep-Wake Disorder has been either ruled in (criterion D rated “3”) or ruled out (criterion D rated “1”)

Specify **associated conditions**: (check all that apply)

___ With non-sleep disorder mental comorbidity

List comorbid mental disorder(s): _______________________

___ With other medical comorbidity

List comorbid medical condition(s):_____________________

___ With other sleep disorders

List comorbid sleep disorder(s): _______________________

?=inadequate information 1=absent or false 2=subthreshold 3=threshold or true
Over the past 3 months, since (3 MONTHS AGO), on average how many days a week have you had trouble staying alert?

Specify current severity: (circle the appropriate number)

Severity rating is based on degree of difficulty maintaining daytime alertness as manifested by the occurrence of multiple attacks of irresistible sleepiness within any given day occurring, for example, while sedentary, driving, visiting with friends, or working.

1 – Mild: Difficulty maintaining daytime alertness 1–2 days/week.

2 – Moderate: Difficulty maintaining daytime alertness 3–4 days/week.

3 – Severe: Difficulty maintaining daytime alertness 5–7 days/week.

? = inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true
SCID-RV (for DSM-5®) (Version 1.0.0) Substance-Induced Sleep Disorder Optional Sleep-Wake Opt-H.9

*SUBSTANCE-INDUCED SLEEP DISORDER (OPTIONAL) (CURRENT ONLY)*

IF CRITERIA NOT MET FOR SUBSTANCE-INDUCED SLEEP DISORDER, RETURN TO EPISODE BEING EVALUATED, CONTINUING WITH THE ITEM FOLLOWING "SYMPTOMS ARE NOT ATTRIBUTABLE TO THE PHYSIOLOGICAL EFFECTS OF A SUBSTANCE" (SEE PAGE NUMBERS IN BOX TO THE RIGHT).

CODE BASED ON INFORMATION ALREADY OBTAINED.

A. A prominent and severe disturbance in sleep. ? 1 2 3 OH42

IF NOT KNOWN: When did the (SLEEP SXS) begin? Were you already using (SUBSTANCE/MEDICATION) or had you just stopped or cut down your use?

IF UNKNOWN: How much (SUBSTANCE/MEDICATION) were you using when you began to have (SLEEP SXS)?

B. There is evidence from the history, physical examination, or laboratory findings of both (1) and (2):

1. The symptoms in criterion A developed during or soon after substance intoxication or withdrawal or exposure to a medication

2. The involved substance/medication is capable of producing the symptoms in Criterion A.

NOTE: Refer to list of etiological substances/medications on page Opt-H.3.

C. The disturbance is NOT better accounted for by a sleep disorder that is not substance-induced. Such evidence of an independent sleep-wake disorder could include the following:

NOTE: The following three statements constitute evidence that the sleep symptoms are not substance-induced. Code "1" if any are true. Code "3" only if none are true.

1) The symptoms precede the onset of the substance/medication use;
2) The symptoms persist for a substantial period of time (e.g., about 1 month) after the cessation of acute withdrawal or severe intoxication; or
3) There is other evidence suggesting the existence of an independent non-substance/medication-induced sleep-wake disorder (e.g., a history of recurrent non-substance/medication-related episodes).

ASK ANY OF THE FOLLOWING QUESTIONS AS NEEDED TO RULE OUT A NON-SUBSTANCE-INDUCED ETIOLOGY:

IF UNKNOWN: Which came first, the (SUBSTANCE/MEDICATION USE) or the (SLEEP SXS)?

IF UNKNOWN: Have you had a period of time when you stopped using (SUBSTANCE/MEDICATION)?

 IF YES: After you stopped using (SUBSTANCE/MEDICATION) did the (SLEEP SXS) go away or get better? IF YES: How long did it take for them to get better? Did they go away within a month of stopping?

IF UNKNOWN: Have you had any other episodes of (SLEEP SXS)?

 IF YES: How many? Were you using (SUBSTANCE/MEDICATION) at those times?

?=inadequate information 1=absent or false 2=subthreshold 3=threshold or true
SCID-RV (for DSM-5®) (Version 1.0.0)  Substance-Induced Sleep Disorder  Optional Sleep-Wake  Opt-H.10

IF UNKNOWN:  What effect have (SLEEP SXS) had on your life?

ASK THE FOLLOWING QUESTIONS AS NEEDED TO RATE CRITERION E:

How have (SLEEP SXS) affected your relationships or your interactions with other people? (Have they caused you any problems in your relationships with your family, romantic partner or friends? Have you been irritable during the day because of [SLEEP SXS])?

How have (SLEEP SXS) affected your work/school? Have (SLEEP SXS) made it more difficult to do your work/schoolwork? (Have they affected the quality of your work/schoolwork)?

Have you missed work or school or had problems at work or school because of (SLEEP SXS)? Have you had trouble thinking clearly because of (SLEEP SXS)?

How have (SLEEP SXS) affected your ability to take care of things at home? What about being involved in things that are important to you like religious activities, physical exercise or hobbies?

Have you felt unsafe to drive or “fallen asleep at the wheel” because of your (SLEEP SXS)? How about it being unsafe for you to do other things that might be dangerous, like operating heavy machinery?

Have (SLEEP SXS) affected any other important part of your life?

IF DO NOT INTERFERE WITH LIFE:  How much have your (SLEEP SXS) bothered or upset you?

NOTE: The D criterion (delirium rule-out) has been omitted.

E. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

RETURN TO DISORDER BEING EVALUATED

?=inadequate information  1=absent or false  2=subthreshold  3=threshold or true

239
SUBSTANCE-INDUCED SLEEP DISORDER
CRITERIA A, B, C, AND E ARE CODED “3.”

Specify if: (circle the appropriate number)

1 – **Insomnia type:** Characterized by difficulty falling asleep or maintaining sleep, frequent nocturnal awakenings, or nonrestorative sleep.

2 – **Daytime sleepiness type:** Characterized by predominant complaint of excessive sleepiness/fatigue during waking hours or, less commonly, a long sleep period.

3 – **Mixed type:** Characterized by a substance/medication-induced sleep problem characterized by multiple types of sleep symptoms, but no symptom clearly predominates.

Indicate context of development of sleep symptoms: (circle the appropriate number)

1 – **With onset during intoxication:** This specifier should be used if criteria are met for intoxication with the substance/medication and symptoms developed during the intoxication period.

2 – **With onset during discontinuation/withdrawal:** This specifier should be used if criteria are met for discontinuation/withdrawal from the substance/medication and symptoms developed during, or shortly after, discontinuation of the substance/medication.

RETURN TO EPISODE BEING EVALUATED

?=inadequate information  1=absent or false  2=subthreshold  3=threshold or true
AVOIDANT RESTRICTIVE FOOD INTAKE DISORDER (OPTIONAL)  
(CURRENT ONLY)*

**SCREEN Q#13a**

IF QUESTION #13a ANSWERED "YES":
You’ve said that in the past month, since (1 MONTH AGO) you have been uninterested in food in general or that you kept forgetting to eat. Tell me about that.

**SCREEN Q#13b**

IF QUESTION #13b ANSWERED "YES":
You’ve [also] said that in the past month, since (1 MONTH AGO) you’ve avoided eating a lot of foods because of the way they look or the way they feel in your mouth. Tell me about that. (How about avoiding foods because they are too chewy or slimy? How about avoiding foods that are too hot or too cold? How about avoiding foods because of their smell?)

**SCREEN Q#13c**

IF QUESTION #13c ANSWERED "YES":
You’ve [also] said that in the past month, since (1 MONTH AGO), you avoided eating a lot of different foods because you were afraid you won’t be able to swallow or that you will choke, gag, or throw up. Tell me about that.

**SCREEN Q#10**

IF SCREENER NOT USED: In the past month, since (1 MONTH AGO), have you been uninterested in food in general or have you kept forgetting to eat?

IF NO: In the past month, since (1 MONTH AGO), have you avoided eating a lot of foods because of the way they look or the way they feel in your mouth? (How about avoiding foods because they are too chewy or slimy? How about avoiding foods that are too hot or too cold? How about avoiding foods because of their smell?)

IF NO: In the past month, since (1 MONTH AGO), have you avoided eating a lot of different foods because you are afraid you won’t be able to swallow or that you will choke, gag, or throw up?

A. An eating or feeding disturbance (e.g., apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; concern about aversive consequences of eating)...

? = inadequate information  
1 = absent or false  
2 = subthreshold  
3 = threshold or true
Because of your (abnormal eating behavior noted above), in the past month...

...have you lost a lot of weight?

1. Significant weight loss (or failure to achieve expected weight gain or faltering growth in children).
   ? 1 2 3 O15

...even if your weight was normal, in the past month have you had a serious vitamin deficiency that required medical attention?

2. Significant nutritional deficiency
   ? 1 2 3 O16

...did you require nutritional supplements or to be fed through a tube? Were they necessary in order for you to regain or maintain your health?

3. Dependence on enteral feeding or oral nutritional supplements.
   ? 1 2 3 O17

...in the past month, since (1 month ago), did your (abnormal eating behavior) interfere with your life in a significant way? (Like by not being able to go out to eat, not go to parties, not go out on dates or away on trips?)

4. Marked interference with psychosocial functioning.
   ? 1 2 3 O18

CRITERION A.1, A.2, A.3, OR A.4 IS CODED "3" 1 3 O19

If unclear: Is this because you haven't been able to get enough food in the past month?

B. The disturbance is not better explained by lack of available food or by an associated culturally sanctioned practice.
   ? 1 2 3 O110

Have you been dieting in the past month? (What kind of diet have you been on?)

Was this part of a religious or spiritual practice, like a fast?

IF SUBJECT IS LOW WEIGHT: Do you feel fat or that part of your body is too fat?

C. The eating disturbance does not occur exclusively during the course of anorexia nervosa or bulimia nervosa, and there is no evidence of a disturbance in the way in which one's body weight or shape is experienced.
   ? 1 2 3 O111

NOTE: Code "3" if no evidence of a disturbance in body image.

?=inadequate information  1=absent or false  2=subthreshold  3=threshold or true
SCID-RV (for DSM-5®) (Version 1.0.0)  ARFID  Optional Feeding and Eating Disorders  Opt-I.3

In the past month, have you been medically ill?

Have you been particularly depressed or anxious?

D. The eating disturbance is not attributable to a concurrent medical condition or not better explained by another mental disorder. When the eating disturbance occurs in the context of another condition or disorder, the severity of the eating disturbance exceeds that routinely associated with the condition or disorder and warrants additional clinical attention.

AVOIDANT/RESTRICTIVE FOOD INTAKE DISORDER CRITERIA A, B, C, AND D ARE CODED "3."

GO TO *OTHER SPECIFIED FEEDING OR EATING DISORDER* I.10

IF UNKNOWN: How old were you when you first started having (SXS OF AVOIDANT/RESTRICTIVE FOOD INTAKE DISORDER)?

Age at onset of Avoidant/Restrictive Food Intake Disorder (CODE 99 IF UNKNOWN)

? = inadequate information  1 = absent or false  2 = subthreshold  3 = threshold or true
J. SOMATIC SYMPTOM AND RELATED DISORDERS (OPTIONAL)

**SOMATIC SYMPTOM DISORDER (OPTIONAL) (CURRENT ONLY)**

A. One or more somatic symptoms that are distressing or result in significant disruption of daily life.

B. Excessive thoughts, feelings, or behaviors related to the somatic symptoms or associated health concerns as manifested by at least one of the following:

1. Disproportionate and persistent thoughts about the seriousness of one’s symptoms.

2. Persistently high level of anxiety about health or symptoms.

**How concerned are you about your symptoms? What are you concerned about? (Have you gone to the doctor about this? What did he or she say? What did you think? Are you more concerned than the doctor suggests you need to be?)**

**How anxious are you about your overall health? Do friends, family, or your doctors think you worry too much about your health?**

**IF NO:** Do you get very anxious whenever you notice a physical symptom? (Tell me about that.)

**How long does this anxiety last?**

?=inadequate information 1=absent or false 2=subthreshold 3=threshold or true
SCID-RV (for DSM-5®) (Version 1.0.0)

Somatic Symptom Disorder

Over the past 6 months, since (6 MONTHS AGO), how much time and energy have you spent...

...thinking about (SXS) or your health?

...going to doctors or getting tests done?

...looking up your symptoms on the internet or in books?

...shopping for supplements or treatments in stores or on the internet?

...talking to friends, family members, or co-workers about your symptoms or your health?

(How often do you check your body for signs of illness, like looking at your throat in the mirror or checking your body for lumps?)

3. Excessive time and energy devoted to these symptoms or health concerns.

AT LEAST ONE "B" SYMPTOM IS CODED "3" ? 1 2 3 OJ6

GO TO *
ILLNESS ANXIETY DISORDER*
Opt-J.3

C. Although any one somatic symptom may not be continuously present, the state of being symptomatic is persistent (typically more than 6 months).

CRITERIA A, B, AND C ARE CODED "3" ? 1 2 3 OJ8

GO TO *
ILLNESS ANXIETY DISORDER*
Opt-J.3

Age-at-onset of Somatic Symptom Disorder (CODE 99 IF UNKNOWN)

Specify if: (check all that apply)

___ With predominant pain: if somatic symptoms predominantly involve pain

___ Persistent: if course is characterized by severe symptoms, marked impairment, and long duration (more than 6 months)

Specify severity: (circle the appropriate number)

1 - Mild: Only one of the symptoms specified in Criterion B are fulfilled

2 - Moderate: Two or more of the symptoms specified in Criterion B are fulfilled.

3 - Severe: Two or more of the symptoms specified in Criterion B are fulfilled, plus there are multiple somatic complaints (or one very severe somatic symptom).

IF UNCLEAR: For most of the time during the past 6 months, have you had physical symptoms of one kind or another?

IF UNKNOWN: How old were you when you first started being very concerned about your health or physical symptoms?

IF UNKNOWN: Of all of these symptoms, which bothers you the most?
*ILLNESS ANXIETY DISORDER (OPTIONAL) (CURRENT ONLY)*

**ILLNESS ANXIETY DISORDER CRITERIA**

**IF SCREENING QUESTION #13e IS ANSWERED "NO," GO TO NEXT MODULE.**

**IF SCREENING QUESTION #13e IS ANSWERED "YES": You’ve said that over the past 6 months, since (6 MONTHS AGO), you’ve spent a lot of time thinking that you have, or will get, a serious disease. What do you think you have or will get? What makes you think so? How much time have you spent thinking about it?**

**IF SCREENER NOT USED: Over the past 6 months, since (6 MONTHS AGO), have you spent a lot of time thinking that you have, or will get, a serious disease?**

**IF YES: What do you think you have or will get? What makes you think so? How much time have you spent thinking about it?**

**Do you have any physical symptoms that make you think you have (FEARED SERIOUS DISEASE)?**

**A. Preoccupation with having, or acquiring a serious illness.**

**DESCRIBE:**

? 1 2 3 OJ14

**GO TO NEXT MODULE**

**B. Somatic symptoms are not present or, if present, are only mild in intensity….**

**NOTE: Code "3" only if no symptoms or if mild in intensity.**

? 1 2 3 OJ15

**GO TO NEXT MODULE**

**Do you actually have (FEARED SERIOUS ILLNESS)? Do you have a family history of (FEARED SERIOUS ILLNESS)?**

**IF YES: Are you more concerned or worried than your doctor or your family thinks you should be? (How much time do you spend thinking about this? More time than you should?)**

**...If another medical condition is present or there is a high risk for developing a medical condition (e.g., strong family history is present), the preoccupation is clearly excessive or disproportionate.**

**NOTE: Code "3" if either (1) there are no other medical conditions and the person is not at risk for a medical condition; or (2) preoccupation with another medical condition is clearly excessive.**

? 1 2 3 OJ16

**GO TO NEXT MODULE**

**How anxious are you about your health and about getting sick?**

**C. There is a high level of anxiety about health and the individual is easily alarmed about personal health status.**

? 1 2 3 OJ17

**GO TO NEXT MODULE**

? = inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true
Do you do things related to your concerns about being sick, such as repeatedly checking your body for signs of illness, repeatedly looking up information on the internet, or repeatedly seeking reassurance from family, friends, doctors, or pharmacists?

**IF NO:** How about avoiding things or situations because of concerns that it might jeopardize your health or increase your anxiety, such as not visiting sick friends in the hospital or avoiding going to funerals? (How about avoiding exercise because you are worried that it might harm your health? How about avoiding going to doctors for regular check-ups or routine tests because you are anxious that they might find something wrong with you?)

**IF UNKNOWN:** How long has this been going on? (At least 6 months)?

How old were you when you first had concerns about having or getting a serious illness that lasted for at least 6 months?

**F.** The illness-related preoccupation is not better explained by another mental disorder, such as Somatic Symptom Disorder, Panic Disorder, Generalized Anxiety Disorder, Body Dysmorphic Disorder, Obsessive-Compulsive Disorder, ...or Delusional Disorder, Somatic Type.

**IF UNKNOWN:** How often do you go to doctors about this?

Specify type (circle the appropriate number)

1 - Care-seeking type: Medical care, including physician visits or undergoing tests and procedures, is frequently used.

2 - Care-avoidant type: Medical care is rarely used.

?= inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true
**INTERMITTENT EXPLOSIVE DISORDER (OPTIONAL) (CURRENT ONLY)**

- **IF SCREENING QUESTIONS #15a AND #15b ARE BOTH ANSWERED “NO,” GO TO *GAMBLING DISORDER* Opt-K.5.**

- **IF SCREENING QUESTION #15a IS ANSWERED “YES”:** You’ve said that in the past year have frequently lost control of your temper and ended up yelling or getting into arguments with others. Tell me about that.

- **IF SCREENING QUESTION #15b IS ANSWERED “YES”:** You’ve (also) said that in the past year, you have lost your temper so that you shoved, hit, kicked or threw something at a person or an animal or damaged someone’s property. Tell me about that.

- **IF SCREENER NOT USED:** In the past year, since (1 YEAR AGO), have you frequently lost control of your temper and ended up yelling or getting into arguments with others? (Tell me about that.)
  - **IF NO:** 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? (Tell me about that.)

**IF THERE IS NO EVIDENCE THAT THE SUBJECT HAS HAD VERBAL OR PHYSICAL AGGRESSION, CHECK HERE ____ AND GO TO *GAMBLING DISORDER* Opt-K.5.**

**IF UNKNOWN:** In the past year, have your angry outbursts resulted in someone getting physically hurt? (Tell me about that.)

**IF UNKNOWN:** In the past year, have you physically injured an animal in anger?

**IF UNKNOWN:** In the past year, have your outbursts resulted in damaging things, breaking things, smashing windows, punching a hole in a wall, or other damage to property?

**IF YES TO ANY OF THESE:** During the past year have you had at least 3 such outbursts?

---

A. Recurrent behavioral outbursts representing a failure to control aggressive impulses as manifested by either of the following:

2. Three behavioral outbursts involving damage or destruction of property and/or physical assault involving physical injury against animals or other individuals occurring within a 12-month period.

**NOTE:** Physical injury includes, at a minimum, a scratch or bruise, whether or not medical attention is sought.

**DESCRIBE:**

? = inadequate information  
1 = absent or false  
2 = subthreshold  
3 = threshold or true
IF UNKNOWN: In the past year, have you had angry outbursts in which you shoved, kicked, hit, or threw something without anything or anyone being damaged or injured?

IF UNKNOWN: In the past year have you also had angry outbursts that involved heated arguments, yelling at people, having temper tantrums, or going on "rants," but without physically hurting anyone or damaging anything?

IF YES TO EITHER: 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?

1. Verbal aggression (e.g., temper tantrums, tirades, verbal arguments or fights) or physical aggression toward property, animals, or other individuals, occurring twice weekly, on average, for a period of 3 months. The physical aggression does not result in damage or destruction of property and does not result in physical injury to animals or other individuals.

Check if:

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EITHER CRITERION A.2 OR A.1 IS CODED "3"?

What kinds of things have set you off? (Do you think your reactions have been much stronger than they should have been given the circumstances? Has anyone told you that your reactions were way off-base given the situation in question?)

B. The magnitude of aggressiveness expressed during the recurrent outbursts is grossly out of proportion to the provocation or to any precipitating psychosocial stressors.

C. The recurrent aggressive outbursts are not premeditated (i.e., they are impulsive and/or anger-based) and are not committed to achieve some tangible objective (e.g., money, power, intimidation).

NOTE: Code "1" if all outbursts are premeditated or intended to achieve a tangible objective.

?=inadequate information  1=absent or false  2=subthreshold  3=threshold or true

GO TO *GAMBLING DISORDER* Opt-K.5

GO TO *GAMBLING DISORDER* Opt-K.5

GO TO *GAMBLING DISORDER* Opt-K.5
SCID-RV (for DSM-5®) (Version 1.0.0)    IED Opt. Externalizing Disorder  Opt-K.3

IF UNKNOWEN:  What effect have your outbursts had on your life in the past year?

ASK THE FOLLOWING QUESTIONS AS NEEDED TO RATE CRITERION D:

Have you gotten into trouble because of them? (For example, 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?)

How have your outbursts affected your relationships or your interactions with other people? (Have they caused you any problems in your relationships with your family, romantic partner or friends?)

How have they affected your work/school? (How about getting fired from a job or expelled from school or getting “written up” for disciplinary action because of your outbursts?)

Have your outbursts affected any other important part of your life?

IF DOES NOT INTERFERE WITH LIFE: How much have you been bothered or upset by your outbursts?

IF HX OF MANIA, DEPRESSION, OR PSYCHOSIS: Did these outbursts happen only when you were feeling excited, irritable, or depressed, or only when you were having (PSYCHOTIC SXS)?

IF HX OF PTSD: Did you have any outbursts like this prior to exposure to (TRAUMATIC EVENT)?

IF HX OF ADHD: Have you gotten any treatment specifically for the aggressive outbursts?

NOTE: Criterion E regarding minimum chronological age has been omitted.

D. The recurrent aggressive outbursts cause either marked distress in the individual or impairment in occupational or interpersonal functioning, or are associated with financial or legal consequences.

F. The recurrent aggressive outbursts are not better explained by another mental disorder (e.g., Major Depressive Disorder, Bipolar Disorder, [Posttraumatic Stress Disorder], Disruptive Mood Dysregulation Disorder, a Psychotic Disorder, Antisocial Personality Disorder, Borderline Personality Disorder)...

Note: This diagnosis can be made in addition to the diagnosis of Attention-Deficit/Hyperactivity Disorder when recurrent impulsive aggressive outbursts are in excess of those usually seen in this disorder and warrant independent clinical attention.

? 1 2 3 OK11
GO TO *GAMBLING DISORDER* Opt-K.5

? 1 2 3 OK12
GO TO *GAMBLING DISORDER* Opt-K.5

? = inadequate information  1 = absent or false  2 = subthreshold  3 = threshold or true
Do you have these outbursts only when you've been drinking, using drugs, or taking medications?

**IF UNKNOWN:** Have you ever had a head injury, seizure, stroke, or some other kind of neurological illness?

**IF YES:** Have these outbursts occurred only during (ILLNESS MENTIONED ABOVE)?

...and are not attributable to another medical condition (e.g., head trauma, Alzheimer's disease) or to the physiological effects of a substance (e.g., alcohol, phencyclidine, cocaine and other stimulants, barbiturates, inhalants, or a medication).

**IF UNKNOWN:** How old were you when you first started having (IED SXS)?

Age at onset of Intermittent Explosive Disorder (CODE 99 IF UNKNOWN).

CRITERIA A, B, C, D, AND F ARE CODED “3”

**GO TO**

*GAMBLING DISORDER* Opt-K.5

CONTINUE WITH NEXT ITEM

**GO TO**

*GAMBLING DISORDER* Opt-K.5

CURRENT IED

**GO TO**

*GAMBLING DISORDER* Opt-K.5

PRIMARY IED

OK13

OK14

OK15

?=inadequate information  1=absent or false  2=subthreshold  3=threshold or true
*GAMBLING DISORDER (OPTIONAL) (CURRENT ONLY)*

**GAMBLING DISORDER CRITERIA**

- IF SCREENING QUESTION #15c IS ANSWERED "NO,"
  - GO TO NEXT MODULE.

- IF SCREENING QUESTION #15c IS ANSWERED "YES": You’ve said that in the past year, you have regularly gambled or regularly bought lottery tickets. What kinds of gambling have you done?

  - IF SCREENER NOT USED: In the past year, since (1 YEAR AGO), have you regularly gambled or regularly bought lottery tickets?
    - IF YES: What kinds of gambling have you done?

  - In the past year, what is the most often you have gambled? What is the largest amount of money that you have won? How about the most you have lost?

  - In the past year...
    - ...has your gambling caused you any problems?
      - ...has anyone objected to your gambling?
      - ...have you hidden from others the amount of time or money that you gambled?
      - ...has your gambling gotten out of control?

- IF NO INCIDENTS OF EXCESSIVE GAMBLING IN PAST YEAR AND THERE IS NO EVIDENCE OF ANY GAMBLING-RELATED PROBLEMS IN THE PAST YEAR, CHECK HERE ___ AND GO TO NEXT MODULE.

Now I’d like to ask you some more questions about your gambling during the past year, since (1 YEAR AGO).

When you have gambled, how have you felt when you were winning? (Excited? On a “high”?) Have you, over time, had to increase the amount of money that you gambled in order to keep getting that same feeling?

A. Persistent and recurrent problematic gambling behavior leading to clinically significant impairment or distress, as indicated by the individual exhibiting four (or more) of the following in a 12-month period:

1. Needs to gamble with increasing amounts of money in order to achieve the desired excitement.

?=inadequate information 1=absent or false 2=subthreshold 3=threshold or true
SCID-RV (for DSM-5®) (Version 1.0.0)


During the past year, since (1 YEAR AGO)...

...have you tried to control your gambling, cut back or stop? Tell me about that. (How many times?) (How successful were you in trying to control it, cut down, or stop?)

2. Has made repeated unsuccessful efforts to control, cut back, or stop gambling.

? 1 2 3 OK26

IF ADMITS TO TRYING TO CUT BACK OR STOP: ...how have you felt when you tried to cut back or stop gambling? (Have you gotten restless or irritable?)

3. Is restless or irritable when attempting to cut down or stop gambling.

? 1 2 3 OK27

NOTE: Code "1" if subject has not tried to cut back or stop.

...how often have you thought about gambling? Have you regularly spent a lot of time planning for the next time you were going to gamble or thinking about how you were going to get the money to gamble with? Have you spent a lot of time thinking about past wins?

4. Is often preoccupied with gambling (e.g., having persistent thoughts of reliving past gambling experiences, handicapping or planning the next venture, thinking of ways to get money with which to gamble).

? 1 2 3 OK28

...besides wanting to win, have there been other reasons that you have gambled? (Have you often gambled to relieve uncomfortable feelings such as feeling helpless, guilty, anxious, or depressed?)

5. Often gambles when feeling distressed (e.g., helpless, guilt, anxious, depressed).

? 1 2 3 OK29

...after having a losing day, do you often go back to try to recover what you’ve lost?

6. After losing money gambling, often returns another day to get even (“chasing” one’s losses).

? 1 2 3 OK30

...have you often lied to others to cover up your gambling, such as about how much time you spent gambling or the amount of money you lost?

7. Lies to conceal the extent of involvement with gambling.

? 1 2 3 OK31

...how has your gambling affected your life? (Have you lost a job or promotion, or done poorly at school because of it? Have you jeopardized or lost a serious relationship over it?)

8. Has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling.

? 1 2 3 OK32

...have you had to rely on family members or friends for money because of your gambling problems?

9. Relies on others to provide money to relieve desperate financial situations caused by gambling.

? 1 2 3 OK33

AT LEAST FOUR “A” ITEMS CODED “3” DURING THE PAST 12 MONTHS

1 3 OK34

GO TO NEXT MODULE

IF HX OF MANIA: Has your gambling only gotten out of control when you have been (high/irritable/OWN WORDS)?

B. The gambling behavior is not better accounted for by a Manic Episode.

NOTE: Code "3" if no history of mania or if gambling occurred when not manic.

1 3 OK35

GO TO NEXT MODULE

?=inadequate information  1=absent or false  2=subthreshold  3=threshold or true
CRITERIA A AND B CODED "3" FOR THE PERIOD OF THE LAST 12 MONTHS

1 3

Indicate severity of Gambling Disorder for past 12 months: (circle the appropriate number)

1 – Mild: 4-5 criteria met

2 – Moderate: 6-7 criteria met.

3 – Severe: 8-9 criteria met.

Specify if: (circle the appropriate number)

IF UNKNOWN: Have your gambling problems gone on continuously or have they come and gone?

1 – Episodic: Meeting diagnostic criteria at more than one time point, with symptoms subsiding between periods of gambling disorder for at least several months.

2 – Persistent: Experiencing continuous symptoms, to meet diagnostic criteria for multiple years.

How old were you when you first started having (SXS OF GAMBLING DISORDER)? Age at onset of Gambling Disorder (CODE 99 IF UNKNOWN).
# Edinburgh Handedness Inventory (EHI)

**Participant ID**

__________________________________

## Edinburgh Handedness Inventory (EHI)

Please mark the box that best describes which hand you use for the activity in question

<table>
<thead>
<tr>
<th>Activity</th>
<th>Always left (1)</th>
<th>Usually left (2)</th>
<th>No preference (3)</th>
<th>Usually right (4)</th>
<th>Always right (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Writing</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>2. Throwing</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>3. Scissors</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>4. Toothbrush</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<tr>
<td>5. Knife (without fork)</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<td>6. Spoon</td>
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<td>○</td>
<td>○</td>
<td>○</td>
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<tr>
<td>7. Match (when striking)</td>
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<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<tr>
<td>8. Computer mouse</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>
Combat Exposure Scale (CES)

Participant ID

__________________________________

Combat Exposure Scale (CES)

Please circle the number above the answer that best describes your experience

1. Did you ever go on combat patrols or have other dangerous duty?
   ○ No (1)   ○ 1-3 times (2)   ○ 4-12 times (3)   ○ 13-50 times (4)   ○ 51+ times (5)

2. Were you ever under enemy fire?
   ○ Never (1)   ○ Less than 1 month (2)   ○ 1-3 months (3)   ○ 4-6 months (4)   ○ 7 months or more (5)

3. Were you ever under enemy fire?
   ○ No (1)   ○ 1-2 times (2)   ○ 3-12 times (3)   ○ 13-25 times (4)   ○ 26+ times (5)

4. What percentage of soldiers in your unit were killed (KIA), wounded or missing in action (MIA)?
   ○ None (1)   ○ 1-25% (2)   ○ 26-50% (3)   ○ 51-75% (4)   ○ 76% or more (5)

5. How often did you fire rounds at the enemy?
   ○ Never (1)   ○ 1-2 times (2)   ○ 3-12 times (3)   ○ 13-50 times (4)   ○ 51+ times (5)

6. How often did you see someone hit by incoming or outgoing rounds?
   ○ Never (1)   ○ 1-2 times (2)   ○ 3-12 times (3)   ○ 13-50 times (4)   ○ 51+ times (5)

7. How often were you in danger of being injured or killed (i.e., being pinned down, overrun, ambushed, near miss, etc.)?
   ○ Never (1)   ○ 1-2 times (2)   ○ 3-12 times (3)   ○ 13-50 times (4)   ○ 51+ times (5)
Morningness-Eveningness Questionnaire (MEQ)

Participant ID ____________________________________

Morningness-Eveningness Questionnaire (MEQ)

1. Considering only your own "feeling best" rhythm, at what time would you get up if you were entirely free to plan your day?
   ○ 5:00 - 6:30 AM (1)
   ○ 6:30 - 7:45 AM (2)
   ○ 7:45 - 9:45 AM (3)
   ○ 9:45 - 11:00 AM (4)
   ○ 11:00 AM - 12:00 PM (5)

2. Considering only your own "feeling best" rhythm, at what time would you go to bed if you were entirely free to plan your evening?
   ○ 8:00 - 9:00 PM (1)
   ○ 9:00 - 10:15 PM (2)
   ○ 10:15 PM - 12:30 AM (3)
   ○ 12:30 - 1:45 AM (4)
   ○ 1:45 - 3:00 AM (5)

3. If there is a specific time at which you would have to get up in the morning, to what extent are you dependent on being woken up by an alarm clock?
   ○ Not at all dependent (1)
   ○ Slightly dependent (2)
   ○ Fairly dependent (3)
   ○ Very dependent (4)

4. Assuming adequate environmental conditions, how easy do you find getting up in the mornings?
   ○ Not at all easy (1)
   ○ Not very easy (2)
   ○ Fairly easy (3)
   ○ Very easy (4)

5. How alert do you feel during the first half hour after having woken in the mornings?
   ○ Not at all alert (1)
   ○ Slightly alert (2)
   ○ Fairly alert (3)
   ○ Very alert (4)

6. How is your appetite during the first half-hour after having woken in the mornings?
   ○ Very poor (1)
   ○ Fairly poor (2)
   ○ Fairly good (3)
   ○ Very good (4)

7. During the first half-hour after having woken in the morning, how tired do you feel?
   ○ Very tired (1)
   ○ Fairly tired (2)
   ○ Fairly refreshed (3)
   ○ Very refreshed (4)
8. When you have no commitments the next day, at what time do you go to bed compared to your usual bedtime?
- Seldom or never later (1)
- Less than one hour later (2)
- 1-2 hours later (3)
- More than two hours later (4)

9. You have decided to engage in some physical exercise. A friend suggests that you do this one hour twice a week and the best time for him is between 7:00-8:00 AM. Bearing in mind nothing else but your own "feeling best" rhythm, how do you think you would perform?
- Would be in good form (1)
- Would be in reasonable form (2)
- Would find it difficult (3)
- Would find it very difficult (4)

10. At what time in the evening do you feel tired and as a result in need of sleep?
- 8:00 - 9:00 PM (1)
- 9:00 - 10:15 PM (2)
- 10:15 PM - 12:45 AM (3)
- 12:45 - 2:00 AM (4)
- 2:00 - 3:00 AM (5)

11. You wish to be at your peak performance for a test which you know if going to be mentally exhausting and lasting for two hours. You are entirely free to plan your day and considering only your own "feeling best" rhythm, which ONE of the four testing times would you choose?
- 8:00 - 10:00 AM (1)
- 11:00 AM - 1:00 PM (2)
- 3:00 - 5:00 PM (3)
- 7:00 - 9:00 PM (4)

12. If you went to bed at 11:00 PM, at what level of tiredness would you be?
- Not at all tired (1)
- A little tired (2)
- Fairly tired (3)
- Very tired (4)

13. For some reason, you have gone to bed several hours later than usual, but there is no need to get up at any particular time the next morning. Which ONE of the following events are you most likely to experience?
- Will wake up at usual time and will NOT fall asleep (1)
- Will wake up at usual time and will doze thereafter (2)
- Will wake up at usual time, but will fall asleep again (3)
- Will NOT wake up until later than usual (4)

14. One night, you have to remain awake between 4:00-6:00 AM in order to carry out a night watch. You have no commitments the next day. Which ONE of the following alternatives will suit you best?
- Would NOT go to bed until the watch was over (1)
- Would take a nap before and sleep after (2)
- Would take a good sleep before and nap after (3)
- Would take ALL sleep before watch (4)

15. You have to do two hours of hard physical work. You are entirely free to plan your day and considering only your own "feeling best" rhythm, which ONE of the following times would you choose?
- 8:00 - 10:00 AM (1)
- 11:00 AM - 1:00 PM (2)
- 3:00 - 5:00 PM (3)
- 7:00 - 9:00 PM (4)
16. You have decided to engage in hard physical exercise. A friend suggests that you do this for one hour twice a week and the best time for him is between 10:00-11:00 PM. Bearing in mind nothing else, but your own "feeling best" rhythm, how well do you think you would perform?

- Would be in good form (1)
- Would be in reasonable form (2)
- Would find it difficult (3)
- Would find it very difficult (4)

17. Suppose that you can choose your own work hours. Assume that you worked a FIVE-hour day (including breaks) and that your job was interesting and paid by results. During which time period would you want that five consecutive hours to END?

- 12:00 - 4:00 AM (1)
- 4:00 - 8:00 AM (2)
- 8:00 - 9:00 AM (3)
- 9:00 AM - 2:00 PM (4)
- 2:00 - 5:00 PM (5)
- 5:00 PM - 12:00 AM (6)

18. At what time of the day do you think that you reach your "feeling best" peak?

- 12:00 - 5:00 AM (1)
- 5:00 - 8:00 AM (2)
- 8:00 - 10:00 AM (3)
- 10:00 AM - 5:00 PM (4)
- 5:00 - 10:00 PM (5)
- 10:00 PM - 12:00 AM (6)

19. One hears about "morning" and "evening" types of people. Which ONE of these types do you consider yourself to be?

- Definitely a "morning" person (1)
- Rather more a "morning" person than an "evening type (2)
- Rather more an "evening" than a "morning" type (3)
- Definitely an "evening" type (4)
The following questions concern your alcohol consumption. Place an X in one box that best describes your answer to each question.

<table>
<thead>
<tr>
<th>Questions</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How often do you have a drink containing alcohol?</td>
<td>Never</td>
<td>Monthly or less</td>
<td>2-4 times a month</td>
<td>2-3 times a week</td>
<td>4 or more times a week</td>
</tr>
<tr>
<td>2. How many drinks containing alcohol do you have on a typical day when you are drinking?</td>
<td>1 or 2</td>
<td>3 or 4</td>
<td>5 or 6</td>
<td>7 to 9</td>
<td>10 or more</td>
</tr>
<tr>
<td>3. How often do you have six or more drinks on one occasion?</td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
</tr>
<tr>
<td>4. How often during the last year have you found that you were not able to stop drinking once you had started?</td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
</tr>
<tr>
<td>5. How often during the last year have you failed to do what was normally expected of you because of drinking?</td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
</tr>
<tr>
<td>6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?</td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
</tr>
<tr>
<td>7. How often during the last year have you had a feeling of guilt or remorse after drinking?</td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
</tr>
<tr>
<td>8. How often during the last year have you been unable to remember what happened the night before because of your drinking?</td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
</tr>
<tr>
<td>9. Have you or someone else been injured because of your drinking?</td>
<td>No</td>
<td>Yes, but not in the last year</td>
<td>Yes, during the last year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?</td>
<td>No</td>
<td>Yes, but not in the last year</td>
<td>Yes, during the last year</td>
<td></td>
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</tr>
</tbody>
</table>

Total
After a head injury or accident some people experience symptoms that can cause worry or nuisance. We would like to know if you now suffer any of the symptoms given below. Because many of these symptoms occur normally, we would like you to compare yourself now with before the accident. For each symptom listed below please circle the number that most closely represents your answer.

0 = not experienced at all
1 = no more of a problem
2 = a mild problem
3 = a moderate problem
4 = a severe problem

Compared with **before** the accident, do you **now** (i.e., over the last 24 hours) suffer from:

<table>
<thead>
<tr>
<th>Symptom</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headaches</td>
<td></td>
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<td></td>
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<tr>
<td>Feelings of dizziness</td>
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<tr>
<td>Nausea and/or vomiting</td>
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<tr>
<td>Noise sensitivity (easily upset by loud noise)</td>
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<tr>
<td>Sleep disturbance</td>
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<tr>
<td>Fatigue, tiring more easily</td>
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<tr>
<td>Being irritable, easily angered</td>
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<tr>
<td>Feeling depressed or tearful</td>
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<td>Feeling frustrated or impatient</td>
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<td>Forgetfulness, poor memory</td>
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<td>Poor concentration</td>
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<td>Taking longer to think</td>
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<td>Blurred vision</td>
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<tr>
<td>Light sensitivity (easily upset by bright light)</td>
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<tr>
<td>Double vision</td>
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<tr>
<td>Restlessness</td>
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</tr>
</tbody>
</table>

Are you experiencing any other difficulties? Please specify, and rate as above.

1.   
2.   

Administration only:

<table>
<thead>
<tr>
<th>RPQ-3 (total for first three items)</th>
</tr>
</thead>
<tbody>
<tr>
<td>RPQ-13 (total for next 13 items)</td>
</tr>
</tbody>
</table>

Rivermead Post Concussion Symptoms Questionnaire (cont.)
Modified (Rpq-3 And Rpq-13)42 Printed With Permission: Modified Scoring System From Eyres 2005 28

Administration only
Individual item scores reflect the presence and severity of post concussive symptoms. Post concussive symptoms, as measured by the RPQ, may arise for different reasons subsequent to (although not necessarily directly because of) a traumatic brain injury. The symptoms overlap with broader conditions, such as pain, fatigue and mental health conditions such as depression72.

The questionnaire can be repeated to monitor a patient’s progress over time. There may be changes in the severity of symptoms, or the range of symptoms. Typical recovery is reflected in a reduction of symptoms and their severity within three months.

Scoring
The scoring system has been modified from Eyres, 200524.

The items are scored in two groups. The first group (RPQ-3) consists of the first three items (headaches, feelings of dizziness and nausea) and the second group (RPQ-13) comprises the next 13 items. The total score for RPQ-3 items is potentially 0–12 and is associated with early symptom clusters of post concussive symptoms. If there is a higher score on the RPQ-3, earlier reassessment and closer monitoring is recommended.

The RPQ-13 score is potentially 0–52, where higher scores reflect greater severity of post concussive symptoms. The RPQ-13 items are associated with a later cluster of symptoms, although the RPQ-3 symptoms of headaches, dizziness and nausea may also be present. The later cluster of symptoms is associated with having a greater impact on participation, psychosocial functioning and lifestyle. Symptoms are likely to resolve within three months. A gradual resumption of usual activities is recommended during this period, appropriate to symptoms. If the symptoms do not resolve within three months, consideration of referral for specialist assessment or treatment services is recommended.

References:

Have you ever used marijuana?
*For our purposes, marijuana usage is considered any instance in which you intentionally consumed (smoked, ingested, etc.) any quantity of marijuana.*

☐ NO    ☐ YES

At what age did you start? ______________________________________________________

At what specific age (in years) was your marijuana usage the heaviest? ______________

During your lifetime, approximately how many occasions have you used marijuana?
☐ 0-50    ☐ 51-100    ☐ 101-500    ☐ 501s-1000    ☐ 1001-5000    ☐ over 5000

Consider the extent of marijuana use throughout your lifetime. Please approximate the number of times per month on average which you used marijuana at the following ages:

<table>
<thead>
<tr>
<th>16-18 years of age</th>
<th>19-21 years of age</th>
<th>22-24 years of age</th>
<th>25-27 years of age</th>
<th>28-30 years of age</th>
<th>30+ years of age</th>
</tr>
</thead>
<tbody>
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<td></td>
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</tbody>
</table>

During your lifetime, on average, how many times per month have you used marijuana?

_____________

In the past *four weeks*, did you use marijuana?

☐ NO    ☐ YES

How often? __________________________________________ daily / weekly (*circle one*)

On average, how much do you consume per occasion? _______________

If YES, please review the printed calendar reflecting all the days in the past month. Indicate the number of times you used marijuana on each of these days. If you abstained from marijuana use during a given day, please write a “0” on that day. Please fill out every day in the calendar with your best guess of marijuana use.
# Blue Test Form

**WRAT 4**

**Name** ____________________________ **Gender** ________

**Grade** ________ **Examiner** ________

## Score Summary Table

<table>
<thead>
<tr>
<th>Subtest/Composite</th>
<th>Raw Score</th>
<th>Standard Score</th>
<th>Confidence Interval</th>
<th>%ile Rank</th>
<th>Optional Scores</th>
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<tbody>
<tr>
<td>Word Reading</td>
<td></td>
<td></td>
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<td>Grade Equivalent</td>
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<tr>
<td>Reading Composite*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Grade Equivalent</td>
</tr>
</tbody>
</table>

*Reading Composite Raw Score = Word Reading Standard Score + Sentence Comprehension Standard Score.

## Standard Score Profile

### Word Reading

- **Standard Score**
- **Confidence Interval**

### Sentence Comprehension

- **Standard Score**
- **Confidence Interval**

### Spelling

- **Standard Score**
- **Confidence Interval**

### Math Computation

- **Standard Score**
- **Confidence Interval**

### Reading Composite

- **Standard Score**
- **Confidence Interval**

### Percentile Rank (PR)

| 1 | 2 | 5 | 6 | 16 | 25 | 57 | 63 | 75 | 84 | 91 | 95 | 98 | 99 |

### Standard Deviation (SD) Units

- 

### Performance Level

- Lower Extreme
- Low
- Below Average
- Average
- Above Average
- Superior
- Upper Extreme

## Standard Score Comparison Table

<table>
<thead>
<tr>
<th>Score Comparisons</th>
<th>Score Difference</th>
<th>Significance Level</th>
<th>Prevalence in Standardization Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; = &lt;</td>
<td>Word Reading</td>
<td>ns .15 .10 .05 .01</td>
<td>&gt;25% 25% 20% 15% 10% 5% 1%</td>
</tr>
<tr>
<td>&gt; = &lt;</td>
<td>Sentence Comprehension</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; = &lt;</td>
<td>Word Reading</td>
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<tr>
<td>&gt; = &lt;</td>
<td>Spelling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; = &lt;</td>
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<td>&gt; = &lt;</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>&gt; = &lt;</td>
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<td>Math Computation</td>
<td>ns .15 .10 .05 .01</td>
<td>&gt;25% 25% 20% 15% 10% 5% 1%</td>
</tr>
</tbody>
</table>
WORD READING SUBTEST

AGES 7 OR YOUNGER: Administer Part 1: Letter Reading first, followed by Part 2: Word Reading. Discontinue testing if a Participant has responded incorrectly to 10 consecutive items (10 RULE).

AGES 8 OR OLDER: Administer Part 2: Word Reading first. Discontinue the Word Reading section if the Participant has answered 10 consecutive items incorrectly (10 RULE). If the Participant has correctly answered 5 or more items on the Word Reading section before meeting the discontinue criterion, do not administer the preliminary Letter Reading section. If the Participant did not answer at least 5 items correctly on the Word Reading section, then administer Part 1: Letter Reading (5 RULE).

Part 1: Letter Reading Administration Instructions

After handing the Participant the Blue Word Reading List, say, I want you to look at the letters on this line. (Point to the row of letters at the top of the card) Read to me the letters one-by-one across the line. After the Participant has finished, say, That’s all. Now let’s do something different.

A B O S E R T H U I V Z J Q
(1) (2) (3) (4) (5) (6) (7) (8) (9) (10) (11) (12) (13) (14) (15)

Part 2: Word Reading Administration Instructions

After handing the Participant the Blue Word Reading List, say, Look at each of these words carefully. (Point to the words) Read the words across the page so I can hear you. When you finish the first line, go right on to the second line, and so on down the page until you finish or I tell you to stop. Read slowly and say the words clearly. Allow 10 seconds for the Participant to respond to each word. If there is no response after 10 seconds, say, OK, try the next one. If you did not hear a word clearly, say, I could not hear you clearly. Please say the word again just as you did the first time. When the Participant has finished the Word Reading section, say, That’s all. Good job. Thanks. Now we are going to do something else.

1. cat
   kat
2. in
   in
3. book
   buk
4. tree
   tree
5. how
   how
6. animal
   an-i-mal
7. hair
   hair
8. spell
   spel
9. even
   ee-vên
10. size
    szî
11. finger
    fing-ger
12. felt
    felt
13. laugh
    laf
14. straight
    strayt
15. stretch
    strech
16. split
    split
17. lame
    leym
18. bulk
    bulk
19. knowledge
    nol-iš
20. abuse
    -byoos, -byooz
21. ceiling
    see-ling
22. diagram
    di-a-gram
23. doubt
    dowt
24. collapse
    kô-laps
25. gigantic
    ji-gan-tic
26. contemporary
    kön-tem-pór-er-eę
27. contagious
    kön-tay-túįs
28. exterior
    ik-stee-er-iąr
29. horizon
    bô-rî-zõn
30. triumph
    tri-úmϕ
31. alcoce
    al-kohv
32. tranquility
    tran-kwil-it-tee
33. efficiency
    i-fish-ên-see
34. inquisitive
    in-kwiz-i-tiv
35. bibliography
    bib-li-og-râ-fee
36. municipal
    myoo-nîs-i-pal
37. unanimous
    you-nan-i-nîs
38. discretionary
    di-skres-ên-er-eę
39. seismograph
    sîz-mô-graf
40. benign
    bi-nîn
41. itinerary
    i-fin-ên-er-eę
42. heresy
    her-ên-see
43. usurp
    yoo-surp, -zurp
44. stratagem
    strat-a-jeem
45. pseudonym
    soo-dô-nîm
46. irascible
    i-ras-î-bel
47. heinous
    hay-nîs
48. poignant
    pôn-yanęt
49. disingenuous
    dis-in-jen-yoo-ŭș
50. covetousness
    kuv-ên-fîs-nes
51. omniscient
    om-nîsh-ênṭ
52. oligarchy
    ol-i-gah-keh
53. egregious
    i-gree-jen
54. assuage
    ă-sway̚ąj
55. terpsichorean
    turp-sî-ko-ree-an

Letter Reading Raw Score

Word Reading Raw Score

Word Reading Total Raw Score

Next administer the Sentence Comprehension subtest, if applicable.

*Use this value for determining starting point on Sentence Comprehension subtest.

SPELLING SUBTEST

AGES 7 OR YOUNGER: Administer Part 1: Letter Writing first, followed by Part 2: Spelling. The Spelling section must be administered individually for participants ages 7 and younger. On the Spelling section, the test should be discontinued after the Participant spells 10 consecutive words incorrectly (10 RULE).

AGES 8 OR OLDER: Administer Part 2: Spelling first. Discontinue if 10 consecutive errors have been made (10 RULE). If the Participant has correctly spelled 5 or more items on the Spelling section before meeting the discontinue criterion, the preliminary Letter Writing section should not be administered. If the Participant does not spell at least 5 words correctly on the Spelling section, then administer Part 1: Letter Writing (5 RULE).
WORD READING SUBTEST

AGES 7 OR YOUNGER: Administer Part 1: Letter Reading first, followed by Part 2: Word Reading. Discontinue testing if a Participant has responded incorrectly to 10 consecutive items (10 RULE).

AGES 8 OR OLDER: Administer Part 2: Word Reading first. Discontinue the Word Reading section if the Participant has answered 10 consecutive items incorrectly (10 RULE). If the Participant has correctly answered 5 or more items on the Word Reading section before meeting the discontinue criterion, do not administer the preliminary Letter Reading section. If the Participant did not answer at least 5 items correctly on the Word Reading section, then administer Part 1: Letter Reading (5 RULE).

Part 1: Letter Reading Administration Instructions

After handing the Participant the Blue Word Reading List, say, I want you to look at the letters on this line. (Point to the row of letters at the top of the card) Read to me the letters one-by-one across the line. After the Participant has finished, say, That's all. Now let's do something different.

Part 2: Word Reading Administration Instructions

After handing the Participant the Blue Word Reading List, say, Look at each of these words carefully. (Point to the words) Read the words across the page so I can hear you. When you finish the first line, go right on to the second line, and so on down the page until you finish or I tell you to stop. Read slowly and say the words clearly. Allow 10 seconds for the Participant to respond to each word. If there is no response after 10 seconds, say, OK, try the next one. If you did not hear a word clearly, say, I could not hear you clearly. Please say the word again just as you did the first time. When the Participant has finished the Word Reading section, say, That's all. Good job. Thanks. Now we are going to do something else.

1. cat
    kat

2. in
    in

3. book
    buak

4. tree
    tree

5. how
    how

6. animal
    an-i-mail

7. hair
    hair

8. spell
    spel

9. even
    ee-vên

10. size
    siz

11. finger
    fing-ër

12. felt
    felt

13. laugh
    laf

14. straight
    strayt

15. stretch
    stretch

16. split
    split

17. lame
    leym

18. bulk
    bulk

19. knowledge
    nol-ij

20. abuse
    é-byoos, -byooz

21. ceiling
    see-ling

22. diagram
    di-à-gram

23. doubt
    dowt

24. collapse
    kô-laps

25. gigantic
    ji-gan-tic

26. contemporary
    kôn-tem-pô-ter

27. contagious
    kôn-tay-jûs

28. exterior
    ik-steer-i-ôr

29. horizon
    bô-rî-zôn

30. triumph
    trî-ûnôf

31. alcool
    al-kohv

32. tranquility
    tran-g-kwîl-i-tee

33. efficiency
    i-fish-ên-see

34. inquisitive
    in-kwîz-i-tiv

35. bibliography
    bib-li-og-rà-fee

36. municipal
    myoo-nîs-i-pal

37. unanimous
    you-nan-i-mûs

38. discretionary
    di-skresh-ô-nêr

39. seismograph
    siz-mô-graf

40. benign
    bê-nil

41. itinerary
    i-fin-ê-rê-ee

42. heresy
    her-ê-sec

43. usurp
    you-surp, -zurp

44. stratagem
    strat-a-jêm

45. pseudonym
    soo-dô-nêm

46. irascible
    i-ras-i-bel

47. heinous
    hay-nîs

48. poignant
    poîn-yânt

49. disingenuous
    dis-in-jen-yoo-ûs

50. covetousness
    kuv-ê-fûs-nes

51. omniscient
    om-nish-ênt

52. oligarchy
    ol-i-gahr-kee

53. egregious
    i-gree-jûs

54. assuage
    ô-swaïj

55. terpsichorean
    turp-sî-ko-ree-ân

Letter Reading Raw Score /15
Word Reading Raw Score /55

Word Reading Total Raw Score /70

Next administer the Sentence Comprehension subtest, if applicable.

*Use this value for determining starting point on Sentence Comprehension subtest.

SPELLING SUBTEST

AGES 7 OR YOUNGER: Administer Part 1: Letter Writing first, followed by Part 2: Spelling. The Spelling section must be administered individually for participants ages 7 and younger. On the Spelling section, the test should be discontinued after the Participant spells 10 consecutive words incorrectly (10 RULE).

AGES 8 OR OLDER: Administer Part 2: Spelling first. Discontinue if 10 consecutive errors have been made (10 RULE). If the Participant has correctly spelled 5 or more items on the Spelling section before meeting the discontinue criterion, the preliminary Letter Writing section should not be administered. If the Participant does not spell at least 5 words correctly on the Spelling section, then administer Part 1: Letter Writing (5 RULE).
*Because the preliminary sections—Letter Reading, Letter Writing, and Oral Math—of each form contain the same items these scores should only be counted once in determining the Combined Subtest raw score. If the preliminary sections were administered twice, use only the higher of the two scores.

### Combined Form Score Summary Table

<table>
<thead>
<tr>
<th>Subtest/Composite</th>
<th>Raw Score</th>
<th>Standard Score</th>
<th>Confidence Interval</th>
<th>%ile Rank</th>
<th>Optional Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Norms: Age: Fall, Spring</td>
<td>85%</td>
<td>90%</td>
<td>95%</td>
</tr>
<tr>
<td>Word Reading</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sentence Comprehension</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spelling</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Math Computation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reading Composite*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Reading Composite Raw Score = Word Reading Standard Score + Sentence Comprehension Standard Score.
## 1. Block Design

**Start**
- Ages 6-8: Item 1
- Ages 9-90: Item 3

**Reverse**
- Ages 9-90: Does not obtain a perfect score on either Item 3 or Item 4, administer the preceding items in reverse order until two consecutive perfect scores are obtained.

**Stop**
- Ages 6-8: After Item 11.

**Record & Score**
- Items 1-4: Score 0, 1, or 2 points.
- Items 5-13: Score 0, 4, 5, 6, or 7 points.

<table>
<thead>
<tr>
<th>Design</th>
<th>Presentation Method</th>
<th>Time Limit</th>
<th>Completion Time</th>
<th>Constructed Design</th>
<th>Score</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Examiner Model and Picture</td>
<td>30&quot;</td>
<td>Trial 1 Trial 2</td>
<td>Trial 1 Trial 2</td>
<td>0 1 2</td>
</tr>
<tr>
<td>2.</td>
<td>Examiner Model and Picture</td>
<td>30&quot;</td>
<td>Trial 1 Trial 2</td>
<td>Trial 1 Trial 2</td>
<td>0 1 2</td>
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<tr>
<td>3.</td>
<td>Examiner Model and Picture</td>
<td>45&quot;</td>
<td>Trial 1 Trial 2</td>
<td>Trial 1 Trial 2</td>
<td>0 1 2</td>
</tr>
<tr>
<td>4.</td>
<td>Examiner Model and Picture</td>
<td>45&quot;</td>
<td>Trial 1 Trial 2</td>
<td>Trial 1 Trial 2</td>
<td>0 1 2</td>
</tr>
<tr>
<td>5.</td>
<td>Picture 60&quot;</td>
<td></td>
<td></td>
<td>21-60 16-20 11-15 1-10</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Picture 60&quot;</td>
<td></td>
<td>21-60 16-20 11-15 1-10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Picture 60&quot;</td>
<td></td>
<td>21-60 16-20 11-15 1-10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Picture 60&quot;</td>
<td></td>
<td>21-60 16-20 11-15 1-10</td>
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<td></td>
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<tr>
<td>9.</td>
<td>Picture 120&quot;</td>
<td>71-120 46-70 31-45 1-30</td>
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<tr>
<td>10.</td>
<td>Picture 120&quot;</td>
<td>61-120 46-60 35-45 1-35</td>
<td></td>
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<tr>
<td>11.</td>
<td>Picture 120&quot;</td>
<td>61-120 46-60 35-45 1-35</td>
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<tr>
<td>12.</td>
<td>Picture 120&quot;</td>
<td>61-120 46-60 35-45 1-35</td>
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<tr>
<td>13.</td>
<td>Picture 120&quot;</td>
<td>101-120 81-100 56-80 1-55</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Maximum Raw Score**
- Ages 6-8: 57
- Ages 9-90: 71

**Block Design Total Raw Score**
2. Vocabulary

Start: Ages 6–90: Item 4

Reverse: Ages 6–59: Does not obtain a perfect score on either Item 4 or Item 5, administer the preceding items in reverse order until two consecutive perfect scores are obtained.

Discontinue: After 3 consecutive scores of 0.


Record & Score: Items 1–3: Score 0 or 1 point. Items 4–5: Score 0 or 2 points. Items 6–31: Score 0, 1, or 2 points. See the Manual for sample responses.

<table>
<thead>
<tr>
<th>Item</th>
<th>Response</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Fish</td>
<td></td>
<td>0 1</td>
</tr>
<tr>
<td>2. Shovel</td>
<td></td>
<td>0 1</td>
</tr>
<tr>
<td>3. Shell</td>
<td></td>
<td>0 1</td>
</tr>
<tr>
<td>4. Shirt</td>
<td></td>
<td>0 2</td>
</tr>
<tr>
<td>5. Car</td>
<td></td>
<td>0 2</td>
</tr>
<tr>
<td>6. Lamp</td>
<td></td>
<td>0 1 2</td>
</tr>
<tr>
<td>7. Bird</td>
<td></td>
<td>0 1 2</td>
</tr>
<tr>
<td>8. Tongue</td>
<td></td>
<td>0 1 2</td>
</tr>
<tr>
<td>9. Pet</td>
<td></td>
<td>0 1 2</td>
</tr>
<tr>
<td>10. Lunch</td>
<td></td>
<td>0 1 2</td>
</tr>
<tr>
<td>11. Bell</td>
<td></td>
<td>0 1 2</td>
</tr>
<tr>
<td>12. Calendar</td>
<td></td>
<td>0 1 2</td>
</tr>
<tr>
<td>13. Alligator</td>
<td></td>
<td>0 1 2</td>
</tr>
<tr>
<td>14. Dance</td>
<td></td>
<td>0 1 2</td>
</tr>
</tbody>
</table>

*If the examinee provides a 2-point response that requires feedback or gives an incorrect (0 point) response, provide corrective feedback as instructed in the Manual.*
<table>
<thead>
<tr>
<th>Item</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>15. Summer</td>
<td>0 1 2</td>
</tr>
<tr>
<td>16. Reveal</td>
<td>0 1 2</td>
</tr>
<tr>
<td>17. Decade</td>
<td>0 1 2</td>
</tr>
<tr>
<td>18. Entertain</td>
<td>0 1 2</td>
</tr>
<tr>
<td>19. Tradition</td>
<td>0 1 2</td>
</tr>
<tr>
<td>20. Enthusiastic</td>
<td>0 1 2</td>
</tr>
<tr>
<td>21. Improvise</td>
<td>0 1 2</td>
</tr>
<tr>
<td>22. Haste</td>
<td>0 1 2</td>
</tr>
<tr>
<td>23. Trend</td>
<td>0 1 2</td>
</tr>
<tr>
<td>24. Impulse</td>
<td>0 1 2</td>
</tr>
<tr>
<td>25. Ruminate</td>
<td>0 1 2</td>
</tr>
<tr>
<td>26. Mollify</td>
<td>0 1 2</td>
</tr>
<tr>
<td>27. Exterminate</td>
<td>0 1 2</td>
</tr>
<tr>
<td>28. Panacea</td>
<td>0 1 2</td>
</tr>
</tbody>
</table>
2. Vocabulary (continued)

<table>
<thead>
<tr>
<th>Item</th>
<th>Response</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>29. Perfunctory</td>
<td>0 1 2</td>
<td></td>
</tr>
<tr>
<td>30. Insipid</td>
<td>0 1 2</td>
<td></td>
</tr>
<tr>
<td>31. Pavid</td>
<td>0 1 2</td>
<td></td>
</tr>
</tbody>
</table>

Maximum Raw Score
Age 6: 41
Ages 7–11: 47
Ages 12–14: 53
Ages 15–90: 59

3. Matrix Reasoning

- Start Ages 6–8:
  Sample Items A & B,
  then Item 1
- Ages 9–90:
  Sample Items A & B,
  then Item 4

Maximum Raw Score
Ages 6–8: 24
Ages 9–90: 30

WASI-II Record Form 5
### 4. Similarities

**Start**
- Ages 6-8: Item 1
- Ages 9-90: Item 4

**Reverse**
Ages 9-90: Does not obtain a perfect score on either Item 4 or Item 5, administer the preceding items in reverse order until two consecutive perfect scores are obtained.

**Discontinue**
After 3 consecutive scores of 0.

**Stop**
Ages 6-8: After Item 22.

---

<table>
<thead>
<tr>
<th>Picture</th>
<th>Item</th>
<th>Response</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>6-8</td>
<td>11</td>
<td>1 2 3 4 5</td>
<td>0 1</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>1 2 3 4 5</td>
<td>0 1</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>1 2 3 4 5</td>
<td>0 1</td>
</tr>
<tr>
<td>9-90</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Verbal Items**

<table>
<thead>
<tr>
<th>Item</th>
<th>Response</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Green–Blue</td>
<td>0 2</td>
</tr>
<tr>
<td>5</td>
<td>Square–Triangle</td>
<td>0 2</td>
</tr>
<tr>
<td>6</td>
<td>Cow–Bear</td>
<td>0 1 2</td>
</tr>
<tr>
<td>7</td>
<td>Shirt–Jacket</td>
<td>0 1 2</td>
</tr>
<tr>
<td>8</td>
<td>Pen–Crayon</td>
<td>0 1 2</td>
</tr>
<tr>
<td>9</td>
<td>Hat–Umbrella</td>
<td>0 1 2</td>
</tr>
<tr>
<td>10</td>
<td>Airplane–Bus</td>
<td>0 1 2</td>
</tr>
<tr>
<td>11</td>
<td>Door–Window</td>
<td>0 1 2</td>
</tr>
<tr>
<td>12</td>
<td>Child–Adult</td>
<td>0 1 2</td>
</tr>
</tbody>
</table>

---

*If the examinee provides a response that suggests he or she does not understand the task, provide the specified prompt in the Manual.

†If the examinee provides a 2-point response that requires feedback or provides an incorrect (0 point) response, provide corrective feedback as instructed in the Manual.
<table>
<thead>
<tr>
<th>Verbal Item</th>
<th>Response</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. Shoulder–Ankle</td>
<td>0 1 2</td>
<td></td>
</tr>
<tr>
<td>14. Love–Hate</td>
<td>0 1 2</td>
<td></td>
</tr>
<tr>
<td>15. Smooth–Rough</td>
<td>0 1 2</td>
<td></td>
</tr>
<tr>
<td>16. Hand–Flag</td>
<td>0 1 2</td>
<td></td>
</tr>
<tr>
<td>17. Wall–Line</td>
<td>0 1 2</td>
<td></td>
</tr>
<tr>
<td>18. Heat–Wind</td>
<td>0 1 2</td>
<td></td>
</tr>
<tr>
<td>19. More–Less</td>
<td>0 1 2</td>
<td></td>
</tr>
<tr>
<td>20. Shadow–Echo</td>
<td>0 1 2</td>
<td></td>
</tr>
<tr>
<td>21. Tradition–Habit</td>
<td>0 1 2</td>
<td></td>
</tr>
<tr>
<td>22. Peace–War</td>
<td>0 1 2</td>
<td></td>
</tr>
<tr>
<td>23. Time–Progress</td>
<td>0 1 2</td>
<td></td>
</tr>
<tr>
<td>24. Memory–Practice</td>
<td>0 1 2</td>
<td></td>
</tr>
</tbody>
</table>

Maximum Raw Score
- Ages 6–8: 41
- Ages 9–90: 45

Similarities Total Raw Score 274
Behavioral Observations

Referral source/Reason for referral/Presenting complaint(s)

Physical appearance

Language (e.g., first/native language, other language, English fluency, expressive and receptive language ability, articulation)

Attention and concentration

Attitude toward testing (e.g., rapport, eager to speak, working habits, interest, motivation, reaction to success/failure)

Affect/Mood

Unusual behaviors/Verbalizations (e.g., perseverations, stereotypic movements, bizarre and atypical verbalizations)

Other notes
Day of Scan Information Questionnaire (DSIQ)

Date __________________________________

Date of Birth __________________________________
(in M-D-Y format)

Height __________________________________
(Inches (4 feet = 48 inches, 5 feet = 60 inches, 6 feet = 72 inches))

Weight __________________________________
(Pounds)

Sex

○ Male
○ Female

What is the highest grade or level of school that you have completed or the highest degree you have obtained?

○ Less than 9th grade
○ Some high school, no diploma
○ High school graduate, or equivalent
○ Some college, no degree
○ Technical/Vocational degree
○ Associate degree
○ Bachelor's degree
○ Master's degree
○ Doctorate degree

With what ethnicity do you identify?

○ White
○ Hispanic/Latino
○ Black/African-American
○ Native-American/American Indian
○ Asian/Pacific Islander
○ Other

Caffeine Use

Did you have any caffeine containing products today?

○ Yes ○ No

How many?

______________________________

On average, how many cups of caffeinated coffee do you drink per day?

______________________________

On average, how many cups of caffeinated tea do you drink per day?

______________________________

On average, how many bottles/cans of caffeinated soda do you drink per day?

______________________________
On average, how many energy drinks do you drink per day?
__________________________________

What brand(s) do you drink?
__________________________________

Do you use any other caffeinated products, such as Vivarin or NoDoz?

☐ Yes  ☐ No

What product(s)?
__________________________________

How much?

((Designate mode of consumption in the next question))

Mode of consumption

((e.g. tablets))

How often?

☐ Day  ☐ Week  ☐ Month

Nicotine Use

Do you smoke cigarettes?

☐ Yes  ☐ No

About how many cigarettes do you smoke per day?
__________________________________

How long have you been smoking?

(Years)

Have you tried to quit?

☐ Yes  ☐ No

How many times?
__________________________________

Did you ever smoke cigarettes in the past?

☐ Yes  ☐ No

How many cigarettes did you smoke per day?
__________________________________

How many years ago did you start smoking?
__________________________________
How many years ago did you quit?
__________________________________

Do you use smokeless tobacco, such as dip or chew?

○ Yes  ○ No

About how much do you use per day?

________________________

((Designate mode of consumption in the next question))

Mode of consumption
________________________

((e.g. pouches))

Did you ever use smokeless tobacco in the past?

○ Yes  ○ No

How much did you use per day?

________________________

((Designate mode of consumption in the next question))

Mode of consumption
________________________

((e.g. pouches))

How many years ago did you start using smokeless tobacco?
__________________________________

How many years ago did you quit?
__________________________________

Do you use any other nicotine-containing products?

○ Yes  ○ No

What product(s)?

__________________________________

How much?

________________________

((Designate mode of consumption in the next question))

Mode of consumption
________________________

((e.g. lozenges))

How often?

○ Day
○ Week
○ Month
Other

Do you take diet pills?

☐ Yes  ☐ No

What brand(s)?

__________________________________

How many?

__________________________________

How often?

☐ Day  ☐ Week  ☐ Month

Are you currently taking any medications, vitamins, or supplements?

☐ Yes  ☐ No

List medication

((e.g. Ibuprofen, 200 mg, Daily))

List medication

__________________________________

List medication

__________________________________

List medication

__________________________________

How many times per month do you drink (alcohol)?

__________________________________

On those occasions, what is the average number of drinks you consume?

__________________________________

On those occasions, what is the largest number of drinks you consume?

__________________________________

How many times in the past year have you used marijuana?

__________________________________

Have you ever used marijuana at other times in your life?

☐ Yes  ☐ No

At what age did you begin smoking marijuana?

__________________________________

On approximately how many occasions have you used marijuana?

__________________________________
Do you use any other street drugs currently or in the past year?

☐ Yes  ☐ No

Which drug(s)?

__________________________________

How much?

((Designate mode of consumption in the next question))

Mode of consumption

__________________________________

((e.g. pills))

How often?

☐ Day  ☐ Week  ☐ Month

---

**Physical Information**

When was your last menstrual period (be as precise as possible)?

(Date of period: _____ or about _____ days ago)

Do you typically eat breakfast?

☐ Yes  ☐ No

Do you eat of snack within 1 hour of waking up?

☐ Yes  ☐ No

Do you typically eat or snack within 1 hour of falling asleep at night?

☐ Yes  ☐ No

Thinking about the past four weeks, on average, how many meals do you have per day?

☐ 0  ☐ 1  ☐ 2  ☐ 3  ☐ 4  ☐ 5  ☐ 6 or more

Thinking about the past four weeks, on average, how many times do you snack per day?

☐ 0  ☐ 1  ☐ 2  ☐ 3  ☐ 4  ☐ 5  ☐ 6 or more
How has your appetite been over the past four weeks on average?

- 1 (Never hungry)
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10 (Always hungry)

Do you feel that you eat more than you intend to?

- 1 (Never)
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10 (Always)

How much do you think you can eat, compared to others your age?

- 1 (Much less than others)
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10 (Much more than others)

When hungry, how much do you crave carbohydrates (e.g. rice, breads, pastas)?

- 1 (Not at all)
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10 (Always)

When hungry, how much do you crave fats (e.g. fried food, red meats, cheese/cream, chips)?

- 1 (Not at all)
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10 (Always)
When hungry, how much do you crave sweets?

- 1 (Not at all)
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10 (Always)

Thinking about the past four weeks, on average, how many servings of fruit and vegetables do you have per day?
(1 Serving = 1/2 cup of raw fruit/vegetables, 1 apple/banana, etc.)

- 0
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10 or more

Thinking about the past four weeks, on average, how many servings of meat, poultry, fish, beans, eggs, and nuts do you have per day?
(1 Serving = 3 oz. meat/poultry/fish, 1/2 cup beans, 2 tbsp. peanut butter, etc.)

- 0
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10 or more

Thinking about the past four weeks, on average, how many times a week do you have microwave meals or eat fast food?

- 0
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10 or more

Do you engage in regular exercise?

- Yes
- No
Thinking about the past four weeks, on average, how many days per week do you exercise?

- 1
- 2
- 3
- 4
- 5
- 6
- 7

Thinking about the past four weeks, on average, how many minutes is each exercise session?

(Minutes)

What percent of your exercise is cardio?

(Percent (%))

What percent of your exercise is strength training?

(Percent (%))

What percent of your exercise is light exercise (e.g. stretching, walking, and some types of yoga)?

(Percent (%))

---

**Sleep Habits**

How many hours of sleep did you get last night?

((e.g. 7.5 for 7 hours 30 minutes of sleep))

Keeping the past four weeks in mind, how many hours do you typically sleep on weeknights (Sun-Thurs)?

__________________________________

Keeping the past four weeks in mind, how many hours do you typically sleep on weekend nights (Fri-Sat)?

__________________________________

Keeping the past four weeks in mind, at what time do you normally go to bed at night on weeknights (Sun-Thurs)?

(In standard time HH:MM)

AM or PM?

- AM
- PM

Keeping the past four weeks in mind, at what time do you normally go to bed at night on weekends (Fri-Sat)?

(In standard time HH:MM)

AM or PM?

- AM
- PM
Keeping the past four weeks in mind, at what time do you typically awaken on weekdays (Mon-Fri)?

__________________________________
(In standard time HH:MM)
AM or PM?
☐ AM
☐ PM

Keeping the past four weeks in mind, at what time do you typically awaken on weekends (Sat-Sun)?

__________________________________
(In standard time HH:MM)
AM or PM?
☐ AM
☐ PM

Keeping the past four weeks in mind, how many minutes does it typically take to fall asleep at night on weeknights (Sun-Thurs)?

__________________________________
(e.g. 15 for 15 minutes)

Keeping the past four weeks in mind, how many minutes does it typically take you to fall asleep at night on weekends (Fri-Sat)?

__________________________________

At what time of day do you feel sleepiest?

__________________________________
(In standard time HH:MM)
AM or PM?
☐ AM
☐ PM

At what time of day do you feel most alert?

__________________________________
(In standard time HH:MM)
AM or PM?
☐ AM  ☐ PM

How many hours do you need to sleep per night to feel your best?

__________________________________

"If I get less than ____ hours of sleep, I notice an impairment in my ability to function at work."

__________________________________

"If I get more than ____ hours of sleep, I notice an impairment in my ability to function at work."

__________________________________

Is daytime sleepiness currently a problem for you?

☐ Yes  ☐ No
Are you currently doing shift work, that is, working early morning, evening, or night shifts?

○ Yes  ○ No

Do you ever have trouble falling asleep?

○ Yes  ○ No

How often per week, month, or year?

((Designate time period in the next question))

Specify time period

○ Week
○ Month
○ Year

Do you ever have trouble staying asleep?

○ Yes  ○ No

How often per week, month, or year?

((Designate time period in the next question))

Specify time period

○ Week
○ Month
○ Year

Do you take more than two daytime naps per month?

○ Yes  ○ No

About how many times per week do you nap?

__________________________________

At what time of day do you normally begin your nap?

__________________________________

(HH:MM)

AM or PM?

○ AM
○ PM

At what time of day do you normally wake up from your nap?

__________________________________

(HH:MM)

AM or PM?

○ AM
○ PM
Do you consider yourself a light, normal, or heavy sleeper?

- ○ Light
- ○ Normal
- ○ Heavy

I yawn often

- ○ 1 (Never)
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7
- ○ 8
- ○ 9
- ○ 10 (Always yawning)

When I see or hear someone else yawn, I will yawn too

- ○ 1 (Never)
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7
- ○ 8
- ○ 9
- ○ 10 (Every time)

---

**Recent Risk of Dozing Off (ESS)**

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in the last two weeks. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

- 0 - Would never doze
- 1 - Slight chance of dozing
- 2 - Moderate chance of dozing
- 3 - High chance of dozing

<table>
<thead>
<tr>
<th>Situation</th>
<th>Would never doze (0)</th>
<th>Slight chance of dozing (1)</th>
<th>Moderate chance of dozing (2)</th>
<th>High chance of dozing (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting and reading</td>
<td>○</td>
<td>○</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Watching TV</td>
<td>○</td>
<td>○</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sitting, inactive in a public place (e.g. a theater or meeting)</td>
<td>○</td>
<td>○</td>
<td></td>
<td></td>
</tr>
<tr>
<td>As a passenger in a car for an hour without a break</td>
<td>○</td>
<td>○</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lying down to rest in the afternoon when circumstances permit</td>
<td>○</td>
<td>○</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sitting and talking to someone</td>
<td>○</td>
<td>○</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sitting quietly after a lunch without alcohol</td>
<td>○</td>
<td>○</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In a car, while stopped for a few minutes in traffic</td>
<td>○</td>
<td>○</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Psychomotor Vigilance Test

Press the spacebar every time an “x” appears on the screen.
Please put an X next to the statement that best describes how you feel:

**Right now I am:**

- [ ] Feeling active, vital, alert or wide awake
- [ ] Functioning at high levels, but not at peak; able to concentrate
- [ ] Awake, but relaxed; responsive but not fully alert
- [ ] Somewhat foggy, let down
- [ ] Foggy; losing interest in remaining awake; slowed down
- [ ] Sleepy, woozy, fighting sleep; prefer to lie down
- [ ] No longer fighting sleep, sleep onset soon; having dream-like thoughts
- [ ] Asleep
# Instructions:
This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the **one statement** in each group that best describes the way you have been feeling during the **past two weeks, including today**. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

## 1. Sadness
0 I do not feel sad.  
1 I feel sad much of the time.  
2 I am sad all the time.  
3 I am so sad or unhappy that I can’t stand it.

## 2. Pessimism
0 I am not discouraged about my future.  
1 I feel more discouraged about my future than I used to be.  
2 I do not expect things to work out for me.  
3 I feel my future is hopeless and will only get worse.

## 3. Past Failure
0 I do not feel like a failure.  
1 I have failed more than I should have.  
2 As I look back, I see a lot of failures.  
3 I feel I am a total failure as a person.

## 4. Loss of Pleasure
0 I get as much pleasure as I ever did from the things I enjoy.  
1 I don’t enjoy things as much as I used to.  
2 I get very little pleasure from the things I used to enjoy.  
3 I can’t get any pleasure from the things I used to enjoy.

## 5. Guilty Feelings
0 I don’t feel particularly guilty.  
1 I feel guilty over many things I have done or should have done.  
2 I feel quite guilty most of the time.  
3 I feel guilty all of the time.

## 6. Punishment Feelings
0 I don’t feel I am being punished.  
1 I feel I may be punished.  
2 I expect to be punished.  
3 I feel I am being punished.

## 7. Self-Dislike
0 I feel the same about myself as ever.  
1 I have lost confidence in myself.  
2 I am disappointed in myself.  
3 I dislike myself.

## 8. Self-Criticalness
0 I don’t criticize or blame myself more than usual.  
1 I am more critical of myself than I used to be.  
2 I criticize myself for all of my faults.  
3 I blame myself for everything bad that happens.

## 9. Suicidal Thoughts or Wishes
0 I don’t have any thoughts of killing myself.  
1 I have thoughts of killing myself, but I would not carry them out.  
2 I would like to kill myself.  
3 I would kill myself if I had the chance.

## 10. Crying
0 I don’t cry any more than I used to.  
1 I cry more than I used to.  
2 I cry over every little thing.  
3 I feel like crying, but I can’t.
11. Agitation
0 I am no more restless or wound up than usual.
1 I feel more restless or wound up than usual.
2 I am so restless or agitated that it’s hard to stay still.
3 I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest
0 I have not lost interest in other people or activities.
1 I am less interested in other people or things than before.
2 I have lost most of my interest in other people or things.
3 It’s hard to get interested in anything.

13. Indecisiveness
0 I make decisions about as well as ever.
1 I find it more difficult to make decisions than usual.
2 I have much greater difficulty in making decisions than I used to.
3 I have trouble making any decisions.

14. Worthlessness
0 I do not feel I am worthless.
1 I don’t consider myself as worthwhile and useful as I used to.
2 I feel more worthless as compared to other people.
3 I feel utterly worthless.

15. Loss of Energy
0 I have as much energy as ever.
1 I have less energy than I used to have.
2 I don’t have enough energy to do very much.
3 I don’t have enough energy to do anything.

16. Changes in Sleeping Pattern
0 I have not experienced any change in my sleeping pattern.
1a I sleep somewhat more than usual.
1b I sleep somewhat less than usual.
2a I sleep a lot more than usual.
2b I sleep a lot less than usual.
3a I sleep most of the day.
3b I wake up 1–2 hours early and can’t get back to sleep.

17. Irritability
0 I am no more irritable than usual.
1 I am more irritable than usual.
2 I am much more irritable than usual.
3 I am irritable all the time.

18. Changes in Appetite
0 I have not experienced any change in my appetite.
1a My appetite is somewhat less than usual.
1b My appetite is somewhat greater than usual.
2a My appetite is much less than before.
2b My appetite is much greater than usual.
3a I have no appetite at all.
3b I crave food all the time.

19. Concentration Difficulty
0 I can concentrate as well as ever.
1 I can’t concentrate as well as usual.
2 It’s hard to keep my mind on anything for very long.
3 I find I can’t concentrate on anything.

20. Tiredness or Fatigue
0 I am no more tired or fatigued than usual.
1 I get more tired or fatigued more easily than usual.
2 I am too tired or fatigued to do a lot of the things I used to do.
3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex
0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.
# Beck Anxiety Inventory (BAI)

Participant ID

---

## Beck Anxiety Inventory (BAI)

Below is a list of common symptoms of anxiety. Please read each item in the list carefully. Indicate how much you have been bothered by each symptom during the PAST WEEK, INCLUDING TODAY by selecting the corresponding space for each symptom.

<table>
<thead>
<tr>
<th></th>
<th>Not at all (0)</th>
<th>Mildly - It did not bother me (1)</th>
<th>Moderately - It was very unpleasant, but I could stand it (2)</th>
<th>Severely - I could barely stand it (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Numbness of tingling</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>2. Feeling hot</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>3. Wobbliness in legs</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>4. Unable to relax</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>5. Fear of the worst happening</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>6. Dizzy or lightheaded</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>7. Heart pounding or racing</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>8. Unsteady</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>9. Terrified</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>10. Nervous</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>11. Feelings of choking</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>12. Hands trembling</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>13. Shaky</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>14. Fear of losing control</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>15. Difficulty breathing</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>16. Fear of dying</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>17. Scared</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>18. Indigestion or discomfort in abdomen</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>19. Faint</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>20. Face flushed</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>21. Sweating (not due to heat)</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>
Evaluation of Risks Scale (EVAR)

Participant ID
_________________________

Evaluation of Risks Scale (EVAR)

1. I feel like gambling
_________________________

2. I am driving and the light turns yellow, I feel like
_________________________

3. The lights suddenly go out in an unfamiliar stairwell
_________________________

4. I feel like
_________________________

5. I feel like diving from a diving board, which is
_________________________

6. I like
_________________________

7. I seek
_________________________

8. I am in a hurry
_________________________

9. I am open to
_________________________

10. I prefer to
_________________________

11. I give priority to
_________________________

12. I like to listen to music
_________________________

13. I am sure of myself
_________________________

14. I prefer discussions, which are
_________________________
15. A hostile situation

16. A menacing dog approaches

17. Faced with a potentially dangerous event

18. Seeing a person who is drowning, I first

19. I prefer work that is

20. I am right

21. I emphasize

22. I like to drive

23. I like to listen to music with a tempo that is

24. I like to take risks
State-Trait Anxiety Inventory for Adults™
Instrument and Scoring Key

Developed by Charles D. Spielberger
in collaboration with R.L. Gorsuch, R. Lushene, P.R. Vagg, and G.A. Jacobs

Published by Mind Garden, Inc.

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SELF-EVALUATION QUESTIONNAIRE STAI Form Y-1

Please provide the following information:

Subject ID ____________________________ Date ____________________________ S ______

Age __________ Gender (Circle) M F T ______

DIRECTIONS:

A number of statements which people have used to describe themselves are given below. Read each statement and then circle the appropriate number to the right of the statement to indicate how you feel right now, that is, at this moment. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe your present feelings best.

1. I feel calm ........................................................................................................................................
   1 2 3 4

2. I feel secure ......................................................................................................................................
   1 2 3 4

3. I am tense .......................................................................................................................................
   1 2 3 4

4. I feel strained ...................................................................................................................................
   1 2 3 4

5. I feel at ease ......................................................................................................................................
   1 2 3 4

6. I feel upset ....................................................................................................................................... 1 2 3 4

7. I am presently worrying over possible misfortunes ......................................................................
   1 2 3 4

8. I feel satisfied ...................................................................................................................................
   1 2 3 4

9. I feel frightened .................................................................................................................................
   1 2 3 4

10. I feel comfortable ............................................................................................................................
    1 2 3 4

11. I feel self-confident ........................................................................................................................
    1 2 3 4

12. I feel nervous ...................................................................................................................................
    1 2 3 4

13. I am jittery ........................................................................................................................................
    1 2 3 4

14. I feel indecisive ................................................................................................................................
    1 2 3 4

15. I am relaxed ....................................................................................................................................
    1 2 3 4

16. I feel content ....................................................................................................................................
    1 2 3 4

17. I am worried .....................................................................................................................................
    1 2 3 4

18. I feel confused ..................................................................................................................................
    1 2 3 4

19. I feel steady .....................................................................................................................................
    1 2 3 4

20. I feel pleasant ....................................................................................................................................
    1 2 3 4
## SELF-EVALUATION QUESTIONNAIRE
### STAI Form Y-2

| Subject ID __________________________ | Date __________ |

### DIRECTIONS

A number of statements which people have used to describe themselves are given below. Read each statement and then circle the appropriate number to the right of the statement to indicate how you **generally** feel.

21. I feel pleasant .......................................................................................................................... 1 2 3 4

22. I feel nervous and restless ...................................................................................................... 1 2 3 4

23. I feel satisfied with myself ...................................................................................................... 1 2 3 4

24. I wish I could be as happy as others seem to be ................................................................. 1 2 3 4

25. I feel like a failure .................................................................................................................. 1 2 3 4

26. I feel rested ............................................................................................................................. 1 2 3 4

27. I am “calm, cool, and collected” ......................................................................................... 1 2 3 4

28. I feel that difficulties are piling up so that I cannot overcome them ................................. 1 2 3 4

29. I worry too much over something that really doesn’t matter ............................................. 1 2 3 4

30. I am happy ............................................................................................................................... 1 2 3 4

31. I have disturbing thoughts ...................................................................................................... 1 2 3 4

32. I lack self-confidence .............................................................................................................. 1 2 3 4

33. I feel secure ............................................................................................................................. 1 2 3 4

34. I make decisions easily ............................................................................................................ 1 2 3 4

35. I feel inadequate ...................................................................................................................... 1 2 3 4

36. I am content ............................................................................................................................. 1 2 3 4

37. Some unimportant thought runs through my mind and bothers me ............................... 1 2 3 4

38. I take disappointments so keenly that I can’t put them out of my mind ......................... 1 2 3 4

39. I am a steady person ................................................................................................................ 1 2 3 4

40. I get in a state of tension or turmoil as I think over my recent concerns and interests .... 1 2 3 4
State-Trait Anxiety Inventory for Adults™

Scoring Key

Developed by Charles D. Spielberger
in collaboration with R.L. Gorsuch, R. Lushene, P.R. Vagg, and G.A. Jacobs

Published by Mind Garden, Inc.

info@mindgarden.com
www.mindgarden.com
State-Trait Anxiety Inventory for Adults Scoring Key (Form Y-1, Y-2)

Developed by Charles D. Spielberger in collaboration with R.L. Gorsuch, R. Lushene, P.R. Vagg, and G.A. Jacobs

To use this stencil, fold this sheet in half and line up with the appropriate test side, either Form Y-1 or Form Y-2. Simply total the scoring weights shown on the stencil for each response category. For example, for question # 1, if the respondent marked 3, then the weight would be 2. Refer to the manual for appropriate normative data.

<table>
<thead>
<tr>
<th>Form Y-1</th>
<th></th>
<th>Form Y-2</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>4</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>2.</td>
<td>4</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>3.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5.</td>
<td>4</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>6.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8.</td>
<td>4</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>9.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10.</td>
<td>4</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>11.</td>
<td>4</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>12.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>14.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>15.</td>
<td>4</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>16.</td>
<td>4</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>17.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>18.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>19.</td>
<td>4</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>20.</td>
<td>4</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>
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Instrument: **State-Trait Anxiety Inventory for Adults**

Authors: **Charles D. Spielberger, in collaboration with R.L. Gorsuch, G.A. Jacobs, R. Lushene, and P.R. Vagg**

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Sincerely,

Robert Most
Mind Garden, Inc.
www.mindgarden.com
Connor-Davidson Resilience Scale (CD-RISC)

Participant ID

Connor-Davidson Resilience Scale (CD-RISC)

For each item, please select the response that best indicates how much you agree with the following statements as they apply to you over the last month. If a particular situation has not occurred recently, answer according to how you think you would have felt.

<table>
<thead>
<tr>
<th></th>
<th>Not true at all (0)</th>
<th>Rarely true (1)</th>
<th>Sometimes true (2)</th>
<th>Often true (3)</th>
<th>True nearly all the time (4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I am able to adapt when changes occur.</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
<tr>
<td>2. I have at least one close and secure relationship that helps me when I am stressed.</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
<tr>
<td>3. When there are no clear solutions to my problems, sometimes fate or God can help.</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
<tr>
<td>4. CI can deal with whatever comes my way.</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
<tr>
<td>5. Past successes give me confidence in dealing with new challenges and difficulties.</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
<tr>
<td>6. I try to see the humorous side of things when I am faced with problems.</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
<tr>
<td>7. Having to cope with stress can make me stronger.</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
<tr>
<td>8. I tend to bounce back after illness, injury, or other hardships.</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
<tr>
<td>9. Good or bad, I believe that most things happen for a reason.</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
<tr>
<td>10. I give my best effort no matter what the outcome may be.</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
<tr>
<td>11. I believe I can achieve my goals, even if there are obstacles.</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
<tr>
<td>12. Even when things look hopeless, I don't give up.</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
<tr>
<td>13. During times of stress/crisis, I know where to turn for help.</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
</tbody>
</table>

15. I prefer to take the lead in solving problems rather than letting others make all the decisions.

16. I am not easily discouraged by failure.

17. I think of myself as a strong person when dealing with life's challenges and difficulties.

18. I can make unpopular or difficult decisions that affect other people, if it is necessary.

19. I am able to handle unpleasant or painful feelings like sadness, fear, and anger.

20. In dealing with life's problems, sometimes you have to act on a hunch without knowing why.

21. I have a strong sense of purpose in my life.

22. I feel in control of my life.

23. I like challenges.

24. I work to attain my goals no matter what roadblocks I encounter along the way.

25. I take pride in my achievements.
PCL-5

Instructions: This questionnaire asks about problems you may have had after a very stressful experience involving actual or threatened death, serious injury, or sexual violence. It could be something that happened to you directly, something you witnessed, or something you learned happened to a close family member or close friend. Some examples are a serious accident; fire; disaster such as a hurricane, tornado, or earthquake; physical or sexual attack or abuse; war; homicide; or suicide.

First, please answer a few questions about your worst event, which for this questionnaire means the event that currently bothers you the most. This could be one of the examples above or some other very stressful experience. Also, it could be a single event (for example, a car crash) or multiple similar events (for example, multiple stressful events in a war-zone or repeated sexual abuse).

Briefly identify the worst event (if you feel comfortable doing so): __________________________

How long ago did it happen? ___________________(please estimate if you are not sure)

Did it involve actual or threatened death, serious injury, or sexual violence?

_____ Yes
_____ No

How did you experience it?

_____ It happened to me directly
_____ I witnessed it
_____ I learned about it happening to a close family member or close friend
_____ I was repeatedly exposed to details about it as part of my job (for example, paramedic, police, military, or other first responder)
_____ Other, please describe ____________________________

If the event involved the death of a close family member or close friend, was it due to some kind of accident or violence, or was it due to natural causes?

_____ Accident or violence
_____ Natural causes
_____ Not applicable (the event did not involve the death of a close family member or close friend)

Second, keeping this worst event in mind, read each of the problems on the next page and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.
In the past month, how much were you bothered by:

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>A little bit</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Repeated, disturbing, and unwanted memories of the stressful experience?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. Repeated, disturbing dreams of the stressful experience?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. Feeling very upset when something reminded you of the stressful experience?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. Avoiding memories, thoughts, or feelings related to the stressful experience?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8. Trouble remembering important parts of the stressful experience?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10. Blaming yourself or someone else for the stressful experience or what happened after it?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12. Loss of interest in activities that you used to enjoy?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13. Feeling distant or cut off from other people?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>15. Irritable behavior, angry outbursts, or acting aggressively?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>16. Taking too many risks or doing things that could cause you harm?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>17. Being “superalert” or watchful or on guard?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>18. Feeling jumpy or easily startled?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>19. Having difficulty concentrating?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>20. Trouble falling or staying asleep?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
Insomnia Severity Index

The Insomnia Severity Index has seven questions. The seven answers are added up to get a total score. When you have your total score, look at the 'Guidelines for Scoring/Interpretation' below to see where your sleep difficulty fits.

For each question, please CIRCLE the number that best describes your answer.

*Please rate the CURRENT (i.e. LAST 2 WEEKS) SEVERITY of your insomnia problem(s).*

**Insomnia Problem**

<table>
<thead>
<tr>
<th>Insomnia Problem</th>
<th>None</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Very Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Difficulty falling asleep</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. Difficulty staying asleep</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. Problems waking up too early</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

4. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

<table>
<thead>
<tr>
<th>Scale</th>
<th>Very Satisfied</th>
<th>Satisfied</th>
<th>Moderately Satisfied</th>
<th>Dissatisfied</th>
<th>Very Dissatisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Very Satisfied</td>
<td>Satisfied</td>
<td>Moderately Satisfied</td>
<td>Dissatisfied</td>
<td>Very Dissatisfied</td>
</tr>
</tbody>
</table>

5. How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

<table>
<thead>
<tr>
<th>Scale</th>
<th>Not at all</th>
<th>Noticeable</th>
<th>A Little</th>
<th>Somewhat</th>
<th>Much</th>
<th>Very Much Noticeable</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Not at all</td>
<td>Noticeable</td>
<td>A Little</td>
<td>Somewhat</td>
<td>Much</td>
<td>Very Much Noticeable</td>
</tr>
</tbody>
</table>

6. How WORRIED/DISTRESSED are you about your current sleep problem?

<table>
<thead>
<tr>
<th>Scale</th>
<th>Not at all</th>
<th>Worried</th>
<th>A Little</th>
<th>Somewhat</th>
<th>Much</th>
<th>Very Much Worried</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Not at all</td>
<td>Worried</td>
<td>A Little</td>
<td>Somewhat</td>
<td>Much</td>
<td>Very Much Worried</td>
</tr>
</tbody>
</table>

7. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?

<table>
<thead>
<tr>
<th>Scale</th>
<th>Not at all</th>
<th>Interfering</th>
<th>A Little</th>
<th>Somewhat</th>
<th>Much</th>
<th>Very Much Interfering</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Not at all</td>
<td>Interfering</td>
<td>A Little</td>
<td>Somewhat</td>
<td>Much</td>
<td>Very Much Interfering</td>
</tr>
</tbody>
</table>

**Guidelines for Scoring/Interpretation:**

Add the scores for all seven items (questions 1 + 2 + 3 + 4 + 5 + 6 + 7) = ______ your total score

Total score categories:

- 0–7 = No clinically significant insomnia
- 8–14 = Subthreshold insomnia
- 15–21 = Clinical insomnia (moderate severity)
- 22–28 = Clinical insomnia (severe)

*Used via courtesy of www.myhealth.va.gov with permission from Charles M. Morin, Ph.D., Université Laval*
INSTRUCTIONS:
The following questions relate to your usual sleep habits during the past month only. Your answers should indicate the most accurate reply for the majority of days and nights in the past month. Please answer all questions.

1. During the past month, what time have you usually gone to bed at night?
   BED TIME ___________

2. During the past month, how long (in minutes) has it usually taken you to fall asleep each night?
   NUMBER OF MINUTES ___________

3. During the past month, what time have you usually gotten up in the morning?
   GETTING UP TIME ___________

4. During the past month, how many hours of actual sleep did you get at night? (This may be different than the number of hours you spent in bed.)
   HOURS OF SLEEP PER NIGHT ___________

For each of the remaining questions, check the one best response. Please answer all questions.

5. During the past month, how often have you had trouble sleeping because you . . .
   a) Cannot get to sleep within 30 minutes
      Not during the past month_____ Less than once a week_____ Once or twice a week_____ Three or more times a week_____
   b) Wake up in the middle of the night or early morning
      Not during the past month_____ Less than once a week_____ Once or twice a week_____ Three or more times a week_____
   c) Have to get up to use the bathroom
      Not during the past month_____ Less than once a week_____ Once or twice a week_____ Three or more times a week_____
d) Cannot breathe comfortably

Not during the past month______ Less than once a week______ Once or twice a week______ Three or more times a week______

e) Cough or snore loudly

Not during the past month______ Less than once a week______ Once or twice a week______ Three or more times a week______

f) Feel too cold

Not during the past month______ Less than once a week______ Once or twice a week______ Three or more times a week______

g) Feel too hot

Not during the past month______ Less than once a week______ Once or twice a week______ Three or more times a week______

h) Had bad dreams

Not during the past month______ Less than once a week______ Once or twice a week______ Three or more times a week______

i) Have pain

Not during the past month______ Less than once a week______ Once or twice a week______ Three or more times a week______

j) Other reason(s), please describe_______________________________________________________________
______________________________________________________________________________________________

How often during the past month have you had trouble sleeping because of this?

Not during the past month______ Less than once a week______ Once or twice a week______ Three or more times a week______

6. During the past month, how would you rate your sleep quality overall?

Very good ____________

Fairly good ____________

Fairly bad ____________

Very bad ____________
7. During the past month, how often have you taken medicine to help you sleep (prescribed or "over the counter")?

Not during the past month once a week a week times a week

8. During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?

Not during the past month once a week a week times a week

9. During the past month, how much of a problem has it been for you to keep up enough enthusiasm to get things done?

No problem at all
Only a very slight problem
Somewhat of a problem
A very big problem

10. Do you have a bed partner or room mate?

No bed partner or room mate
Partner/room mate in other room
Partner in same room, but not same bed
Partner in same bed

If you have a room mate or bed partner, ask him/her how often in the past month you have had . . .

a) Loud snoring

Not during the past month once a week a week times a week

b) Long pauses between breaths while asleep

Not during the past month once a week a week times a week

c) Legs twitching or jerking while you sleep

Not during the past month once a week a week times a week
d) Episodes of disorientation or confusion during sleep

<table>
<thead>
<tr>
<th>Not during the past month</th>
<th>Less than once a week</th>
<th>Once or twice a week</th>
<th>Three or more times a week</th>
</tr>
</thead>
</table>

e) Other restlessness while you sleep; please describe______________________________

<table>
<thead>
<tr>
<th>Not during the past month</th>
<th>Less than once a week</th>
<th>Once or twice a week</th>
<th>Three or more times a week</th>
</tr>
</thead>
</table>
### PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

**SUBJECT #:** ________________________________  **DATE:** ________________________________

Over the last 2 weeks, how often have you been bothered by any of the following problems?

*use “✓” to indicate your answer*

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead, or of hurting yourself</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

(add columns)  

**TOTAL:** ________________

*(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.)*

---

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

<table>
<thead>
<tr>
<th>Difficulty Level</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not difficult at all</td>
<td>______</td>
</tr>
<tr>
<td>Somewhat difficult</td>
<td>______</td>
</tr>
<tr>
<td>Very difficult</td>
<td>______</td>
</tr>
<tr>
<td>Extremely difficult</td>
<td>______</td>
</tr>
</tbody>
</table>

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PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓'s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder
- if there are at least 5 ✓'s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder
- if there are 2-4 ✓'s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient. Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓'s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying PHQ-9 Scoring Box to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1; More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

<table>
<thead>
<tr>
<th>Total Score</th>
<th>Depression Severity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-4</td>
<td>Minimal depression</td>
</tr>
<tr>
<td>5-9</td>
<td>Mild depression</td>
</tr>
<tr>
<td>10-14</td>
<td>Moderate depression</td>
</tr>
<tr>
<td>15-19</td>
<td>Moderately severe depression</td>
</tr>
<tr>
<td>20-27</td>
<td>Severe depression</td>
</tr>
</tbody>
</table>

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A2662B 10-04-2005
Disturbing Dream and Nightmare Severity Index

1. How often do you have disturbing dreams and/or nightmares: (Circle one, then follow the arrow)
   - Never ➔ STOP HERE: NO OTHER QUESTIONS NEED TO BE ANSWERED
   - Yearly ➔ Monthly ➔ Weekly

2. Please estimate the NUMBER of months or years you have had disturbing dreams and/or nightmares:
   _____ months   _____ years

3. On average, do your nightmares wake you up? (Circle answer)
   - Never/Rarely          Occasionally          Sometimes          Frequently          Always

4. How would you rate the SEVERITY of your disturbing dreams and/or nightmare problem? (Circle answer)
   - No Problem            Minimal Problem        Mild Problem          Moderate Problem        Severe Problem          Very Severe Problem      Extremely Severe Problem

5. How would you rate the INTENSITY of your disturbing dreams and/or nightmares? (Circle answer)
   - Not Intense            Minimal Intensity       Mild Intensity         Moderate Intensity       Severe Intensity         Very Severe Intensity     Extremely Severe Intensity

© SHHI 04.16.03
Initials_________
Disturbing Dream and Nightmare Severity Index (cont.)

6. My disturbing dreams or nightmares cause me to lose sleep:
   Not at All  Slightly  Moderately  Very Much  A Great Deal

7. My disturbing dreams or nightmares make it difficult to fall asleep:
   Not at All  Slightly  Moderately  Very Much  A Great Deal

8. My disturbing dreams or nightmares interfere with the quality of my sleep:
   Not at All  Slightly  Moderately  Very Much  A Great Deal

9. My disturbing dreams or nightmares make it difficult to sleep through the night:
   Not at All  Slightly  Moderately  Very Much  A Great Deal

10. My disturbing dreams or nightmares interfere with my mood:
    Not at All  Slightly  Moderately  Very Much  A Great Deal

11. My disturbing dreams or nightmares interfere with my mental health:
    Not at All  Slightly  Moderately  Very Much  A Great Deal

12. My disturbing dreams or nightmares interfere with my physical health:
    Not at All  Slightly  Moderately  Very Much  A Great Deal

13. My disturbing dreams or nightmares interfere with social or recreational activities:
    Not at All  Slightly  Moderately  Very Much  A Great Deal

14. My disturbing dreams or nightmares interfere with my school or work performance:
    Not at All  Slightly  Moderately  Very Much  A Great Deal

15. My disturbing dreams or nightmares interfere with my relationships:
    Not at All  Slightly  Moderately  Very Much  A Great Deal
Functional Outcome of Sleep Questionnaire (FOSQ)

1) Subject ID __________________________________

2) Date __________________________________

Some people have difficulty performing everyday activities when they feel tired or sleepy. The purpose of this questionnaire is to find out if you generally have difficulty carrying out certain activities because you are too sleepy or tired. In this questionnaire, when the words "sleepy" or "tired" are used, it means the feeling that you can't keep your eyes open, your head is droopy, that you want to "nod off," or that you feel the urge to take a nap. These words do not refer to the tired or fatigued feeling you may have after you have exercised.

Please circle one answer for each question. Please try to be as accurate as possible.

0 - I don't do this for other reasons
1 - No difficulty
2 - Yes, a little difficulty
3 - Yes, moderate difficulty
4 - Yes, extreme difficulty

<table>
<thead>
<tr>
<th>I don't do this activity for other reasons (0)</th>
<th>No difficulty (1)</th>
<th>Yes, a little difficulty (2)</th>
<th>Yes, moderate difficulty (3)</th>
<th>Yes, extreme difficulty (4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3) 1. Do you generally have difficulty concentrating on things you do because you are sleepy or tired?</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>4) 2. Do you generally have difficulty remembering things because you are sleepy or tired?</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>5) 3. Do you have difficulty finishing a meal because you become sleepy or tired?</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<tr>
<td>6) 4. Do you have difficulty working on a hobby (for example: sewing, collecting, gardening) because you are sleepy or tired?</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<tr>
<td>7) 5. Do you have difficulty doing work around the house (for example: cleaning house, doing laundry, taking out the trash, repair work) because you are sleepy or tired?</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<tr>
<td>8) 6. Do you have difficulty operating a motor vehicle for short distances (less than 100 miles) because you become sleepy or tired?</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
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</tbody>
</table>
7. Do you have difficulty operating a motor vehicle for long distances (greater than 100 miles) because you become sleepy or tired?

10) 8. Do you have difficulty getting things done because you are too sleepy or tired to drive or take public transportation?

11) 9. Do you have difficulty taking care of financial affairs and doing paperwork (for example: writing checks, paying bills, keeping financial records, filling out tax forms, etc.) because you are sleepy or tired?

12) 10. Do you have difficulty performing employed or volunteer work because you are sleepy or tired?

I don't do this activity for other reasons (0) No difficulty (1) Yes, a little difficulty (2) Yes, moderate difficulty (3) Yes, extreme difficulty (4)

13) 11. Do you have difficulty maintaining a telephone conversation because you become sleepy or tired?

14) 12. Do you have difficulty visiting with your family or friends in your home because you become sleepy or tired?

15) 13. Do you have difficulty visiting with your family or friends in their homes because you become sleepy or tired?

16) 14. Do you have difficulty doing things for your family or friends because you become sleepy or tired?

17) 15. Has your relationship with family, friends or work colleagues been affected because you are sleepy or tired?

18) 16. Do you have difficulty exercising or participating in a sporting activity because you are too sleepy or tired?

19) 17. Do you have difficulty watching a movie or videotape because you become sleepy or tired?

20)
18. Do you have difficulty enjoying the theater or a lecture because you become sleepy or tired?  

19. Do you have difficulty enjoying a concert because you become sleepy or tired?  

20. Do you have difficulty watching television because you are sleepy or tired?  

21. Do you have difficulty participating in religious services, meetings or a group club because you are sleepy or tired?  

22. Do you have difficulty being as active as you want to be in the evening because you are sleepy or tired?  

23. Do you have difficulty being as active as you want to be in the morning because you are sleepy or tired?  

24. Do you have difficulty being as active as you want to be in the afternoon because you are sleepy or tired?  

25. How would you rate yourself in your general level of activity?  

26. How would you rate yourself in your general level of activity?  

27. Has your intimate or sexual relationship been affected because you are sleepy or tired?  

28. Has your desire for intimacy or sex been affected because you are sleepy or tired?  

29. Has your ability to become sexually aroused been affected because you are sleepy or tired?
30. Has your ability to have an orgasm been affected because you are sleepy or tired?

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<th>Subject #</th>
<th>Age</th>
<th>Sex</th>
<th>Education Level</th>
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<th>Ethnicity</th>
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<th>Immediate Memory</th>
<th>Visual-Spatial Construction</th>
<th>Language</th>
<th>Attention</th>
<th>Delayed Memory</th>
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<td>Percentile</td>
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</tbody>
</table>

Observations: ____________________________

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# List Learning

## Trial 1
SAY:  *I am going to read you a list of words. I want you to listen carefully and, when I finish, repeat back as many words as you can. You don’t have to say them in the same order that I do—just repeat back as many words as you can remember, in any order. Okay?*

## Trials 2–4
SAY:  *I am going to read the list again. When I finish, repeat back as many words as you can, even if you have already said them before. Okay?*

Record responses in order.

Scoring: 1 point for each word correctly recalled on each trial.

<table>
<thead>
<tr>
<th>List</th>
<th>Trial 1</th>
<th>Trial 2</th>
<th>Trial 3</th>
<th>Trial 4</th>
</tr>
</thead>
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<td>Powder</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Number Correct**

<table>
<thead>
<tr>
<th>Total Trial 1</th>
<th>Total Trial 2</th>
<th>Total Trial 3</th>
<th>Total Trial 4</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Range: 0–40
# Story Memory

**Trial 1**

Say *I am going to read you a short story. I'd like you to listen carefully and, when I finish, repeat back as much of the story as you can remember. Try and use the same wording, if you can. Okay?*

Read the story below, then say **Now repeat back as much of that story as you can.**

**Trial 2**

Say *I am going to read that same story again. When I finish, I want you to again repeat back as much of the story as you can remember. Try to repeat it as exactly as you can.*

Read the story below, then say **Now repeat back as much of that story as you can.**

Scoring: 1 point for verbatim recall of bold, italic words or alternatives, shown below in color within parentheses. Record intrusions or variations in the Responses column.

<table>
<thead>
<tr>
<th>Story</th>
<th>Trial 1 Responses</th>
<th>Trial 1 Score (0 or 1)</th>
<th>Trial 2 Responses</th>
<th>Trial 2 Score (0 or 1)</th>
<th>Item Score (0–2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. On <em>Tuesday,</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. <em>May</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. <em>Fourth,</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. in <em>Cleveland,</em> Ohio,</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. a <em>3 alarm</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. <em>fire</em> broke out.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. <em>Two</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. <em>hotels</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. and a <em>restaurant</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. were <em>destroyed</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. before the <em>firefighters (firemen)</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. were able to <em>extinguish it</em> <em>(put it out).</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total Score (Trial 1 + Trial 2)  
Range=0–24
Fold this page back and present the Figure Copy Drawing Page along with the stimulus. Ask the examinee to make an exact copy of the figure. Tell the examinee that he or she is being timed, but that the score is based only on the exactness of his or her copy.

Scoring: 1 point for correctness and completeness (drawing), and 1 point for proper placement. See Appendix 1 in Stimulus Booklet A for complete scoring criteria and scoring examples.

### Figure Copy Criteria

(Fold back for use.)

<table>
<thead>
<tr>
<th>Item</th>
<th>Drawing (0 or 1)</th>
<th>Placement (0 or 1)</th>
<th>Score (0, 1, or 2)</th>
<th>Scoring Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. rectangle</td>
<td></td>
<td></td>
<td></td>
<td>Drawing: lines are unbroken and straight; angles 90 degrees; top/bottom lines 25% longer than sides Placement: not rotated more than 15 degrees</td>
</tr>
<tr>
<td>2. diagonal cross</td>
<td></td>
<td></td>
<td></td>
<td>Drawing: lines are unbroken and straight and should approximately bisect each other Placement: ends of lines should meet corners of the rectangle without significant overlap or measurable distance between the ends of the lines and the corners</td>
</tr>
<tr>
<td>3. horizontal line</td>
<td></td>
<td></td>
<td></td>
<td>Drawing: line is unbroken and straight; should not exceed 1/2 the length of the rectangle Placement: should bisect left side of the rectangle at approximately a right angle and intersect the diagonal cross</td>
</tr>
<tr>
<td>4. circle</td>
<td></td>
<td></td>
<td></td>
<td>Drawing: round, unbroken and closed; diameter should be approximately 1/4–1/3 height of rectangle Placement: placed in appropriate segment; not touching any other part of figure</td>
</tr>
<tr>
<td>5. 3 small circles</td>
<td></td>
<td></td>
<td></td>
<td>Drawing: round, unbroken and closed; equal size; triangular arrangement; not touching each other Placement: in appropriate segment; not touching figure; triangle formed not rotated more than 15 degrees</td>
</tr>
<tr>
<td>6. square</td>
<td></td>
<td></td>
<td></td>
<td>Drawing: must be closed; 90 degree angles; lines straight and unbroken; height is 1/4–1/3 height of rectangle Placement: in appropriate segment; not touching any other part of figure; not rotated more than 15 degrees</td>
</tr>
<tr>
<td>7. curving line</td>
<td></td>
<td></td>
<td></td>
<td>Drawing: 2 curved segments are approximately equal in length and symmetrical; correct direction of curves Placement: ends of line touch diagonal; do not touch corner of rectangle or intersection of diagonal lines</td>
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<tr>
<td>8. outside cross</td>
<td></td>
<td></td>
<td></td>
<td>Drawing: vertical line of the outside cross is parallel to side of rectangle; &gt;1/2 the height of rectangle; horizontal line crosses vertical at 90 degree angle and is between 20–50% of length of vertical line Placement: horizontal line of outside cross touches rectangle higher than 2/3 the height of rectangle, but below top; does not penetrate the rectangle</td>
</tr>
<tr>
<td>9. triangle</td>
<td></td>
<td></td>
<td></td>
<td>Drawing: angle formed by 2 sides of triangle is between 60–100 degrees; sides are straight, unbroken and meet in a point; distance on vertical side of rectangle subsumed by triangle is approximately 50% of the height of vertical side Placement: roughly centered on the left vertical side of the rectangle</td>
</tr>
<tr>
<td>10. arrow</td>
<td></td>
<td></td>
<td></td>
<td>Drawing: straight and unbroken; lines forming arrow are approximately equal in length and not more than 1/3 length of staff Placement: must protrude from appropriate corner of rectangle such that staff appears to be continuation of diagonal cross</td>
</tr>
</tbody>
</table>

Total Score Range: 0–20
### Line Orientation

Present the sample item, and say *These two lines down here* (indicate) match two of the lines on top. *Can you tell me the numbers, or point to the lines that they match?* Correct any errors and make sure the examinee understands the task. Continue with Items 1–10.

**Scoring:** 1 point for each line correctly identified.

<table>
<thead>
<tr>
<th>Item</th>
<th>Responses</th>
<th>Correct Responses</th>
<th>Score (0, 1, or 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample</td>
<td>10, 12</td>
<td>1, 7</td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>10, 12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>4, 11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>6, 9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>8, 13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>2, 4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item</th>
<th>Responses</th>
<th>Correct Responses</th>
<th>Score (0, 1, or 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.</td>
<td></td>
<td>1, 6</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td></td>
<td>3, 10</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td></td>
<td>5, 8</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td></td>
<td>1, 3</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td></td>
<td>11, 13</td>
<td></td>
</tr>
</tbody>
</table>

**Total Score Range=0–20**

### Picture Naming

Ask the examinee to name each picture. Give the semantic cue only if the picture is obviously misperceived.

**Scoring:** 1 point for each item that is correctly named spontaneously or following semantic cue.

<table>
<thead>
<tr>
<th>Item</th>
<th>Semantic Cue</th>
<th>Responses</th>
<th>Score (0 or 1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>chair</td>
<td>a piece of furniture</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>pencil</td>
<td>used for writing</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>well</td>
<td>you get water from it</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>giraffe</td>
<td>an animal</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>sailboat</td>
<td>used on the water (if &quot;boat,&quot; query &quot;what kind&quot;)</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>cannon</td>
<td>a weapon, used in war</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>pliers</td>
<td>a tool</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>trumpet</td>
<td>a musical instrument (&quot;cornet&quot; okay)</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>clothespin</td>
<td>used to hold laundry on a line</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>kite</td>
<td>it's flown in the air</td>
<td></td>
</tr>
</tbody>
</table>

**Total Score Range=0–10**
Semantic Fluency

Say Now I'd like you to tell me the names of all of the different kinds of fruits and vegetables that you can think of. I'll give you one minute to come up with as many as you can. Ready?

Scoring: 1 point for each correct response.

1. 
2. 
3. 
4. 
5. 
6. 
7. 
8. 
9. 
10. 
11. 
12. 
13. 
14. 
15. 
16. 
17. 
18. 
19. 
20. 
21. 
22. 
23. 
24. 
25. 
26. 
27. 
28. 
29. 
30. 
31. 
32. 
33. 
34. 
35. 
36. 
37. 
38. 
39. 
40. 

Total Score
Range=0–40

Digit Span

Say I am going to say some numbers, and I want you to repeat them after me. Okay?
Read the numbers at the rate of 1 per second. Only read the second string in each set if the first string was failed. Discontinue after failure of both strings in any set.

Scoring: 2 points for the first string correct, 1 point for the second string correct, and 0 points for both strings failed.

<table>
<thead>
<tr>
<th>Item</th>
<th>First String</th>
<th>String Score (0 or 2)</th>
<th>Second String</th>
<th>String Score (0 or 1)</th>
<th>Item Score (0–2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>4—9</td>
<td></td>
<td>5—3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>8—3—5</td>
<td></td>
<td>2—4—1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>7—2—4—6</td>
<td></td>
<td>1—6—3—8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>5—3—9—2—4</td>
<td></td>
<td>3—8—4—9—1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>6—4—2—9—3—5</td>
<td></td>
<td>9—1—5—3—7—6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>2—8—5—1—9—3—7</td>
<td></td>
<td>5—3—1—7—4—9—2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>8—3—7—9—5—2—4—1</td>
<td></td>
<td>9—5—1—4—2—7—3—8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>1—5—9—2—3—8—7—4—6</td>
<td></td>
<td>5—1—9—7—6—2—3—6—5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total Score
Range=0–16
Look at these boxes (indicate key). For each one of these marks there is a number that goes with it. Down here there are marks, but no numbers. I want you to fill in the number that goes with each mark.

Demonstrate the first three. Say Now I would like you to fill in the rest of these boxes up to the double lines (indicate) for practice. Correct any errors as they are made. Make sure that the examinee understands the task and has correctly completed the sample items before you begin timing.

Say Now I would like you to continue to fill in the numbers that match the marks. Go as quickly as you can without skipping any. When you reach the end of the line, go on to the next one. Ready? Go ahead.

Redirect the examinee to the task if he or she becomes distracted. If the examinee is unable to comprehend the task, the subtest score is 0.

Scoring: 1 point for each item correctly coded within 90 seconds (do not score the sample items).

Note: Familiarize yourself with these instructions before administering this subtest.
### List Recall

Say *Do you remember the list of words that I read to you in the beginning? Tell me as many of those words as you can remember now.*

Scoring: 1 point for each word correctly recalled.

<table>
<thead>
<tr>
<th>List</th>
<th>Response</th>
<th>Score (0 or 1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Market</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Package</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elbow</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Apple</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Story</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carpet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bubble</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highway</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Saddle</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Powder</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total Score
Range=0–10

### List Recognition

Say *I’m going to read you some words. Some of these words were on that list, and some of them weren’t. I want you to tell me which words were on the list. For each word, ask Was _______ on the list?*

Scoring: 1 point for each word correctly identified. Circle the letter corresponding to examinee’s response (*y* = yes, *n* = no); bold, capitalized (Y, N) letter indicates correct response.

<table>
<thead>
<tr>
<th>List</th>
<th>Circle One</th>
<th>List</th>
<th>Circle One</th>
<th>List</th>
<th>Circle One</th>
<th>List</th>
<th>Circle One</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. honey</td>
<td>y</td>
<td>7. velvet</td>
<td>y</td>
<td>12. prairie</td>
<td>y</td>
<td>17. Powder</td>
<td>Y</td>
</tr>
<tr>
<td>5. fabric</td>
<td>y</td>
<td>10. Elbow</td>
<td>Y</td>
<td>15. student</td>
<td>y</td>
<td>20. meadow</td>
<td>y</td>
</tr>
</tbody>
</table>

Total Score
Range=0–20
Say *Do you remember that story about a fire that I read to you earlier? Tell me as many details from the story as you can remember now.*

Scoring: 1 point for each verbatim recall of bold, italic words or alternatives, shown below in color within parentheses. Record intrusions or variations in the Responses column.

<table>
<thead>
<tr>
<th>Story (Do not read.)</th>
<th>Responses</th>
<th>Item Score (0 or 1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. On <strong>Tuesday</strong>,**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. <strong>May</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. <strong>Fourth,</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. in <strong>Cleveland,</strong> Ohio,**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. a <strong>3 alarm</strong></td>
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<td></td>
</tr>
<tr>
<td>6. <strong>fire</strong> broke out.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. <strong>Two</strong></td>
<td></td>
<td></td>
</tr>
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<td>8. <strong>hotels</strong></td>
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<tr>
<td>9. and a <strong>restaurant</strong></td>
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<td></td>
</tr>
<tr>
<td>10. were <strong>destroyed</strong></td>
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<td></td>
</tr>
<tr>
<td>11. before the <strong>firefighters</strong> (firemen)**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. were able to <strong>extinguish it</strong> (put it out)**</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total Score
Range=0–12
Figure Recall

Say *Do you remember that figure that I had you copy? I want you to draw as much of it as you can remember now. If you remember a part, but you’re not sure where it goes, put it anywhere. Try to draw as much of it as you can.*

Now, present the Figure Recall Drawing Page.

Scoring: 1 point for correctness and completeness (drawing), and 1 point for proper placement. See Appendix 1 in Stimulus Booklet A for complete scoring criteria and scoring examples.

---

**Figure Recall Criteria**
*(Fold back for use.)*

<table>
<thead>
<tr>
<th>Item</th>
<th>Drawing (0 or 1)</th>
<th>Placement (0 or 1)</th>
<th>Score (0, 1, or 2)</th>
<th>Scoring Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. rectangle</td>
<td></td>
<td></td>
<td></td>
<td>Drawing: lines are unbroken and straight; angles 90 degrees; top/bottom lines 25% longer than sides Placement: not rotated more than 15 degrees</td>
</tr>
<tr>
<td>2. diagonal cross</td>
<td></td>
<td></td>
<td></td>
<td>Drawing: lines are unbroken and straight and should approximately bisect each other Placement: ends of lines should meet corners of the rectangle without significant overlap or measurable distance between the ends of the lines and the corners</td>
</tr>
<tr>
<td>3. horizontal line</td>
<td></td>
<td></td>
<td></td>
<td>Drawing: line is unbroken and straight; should not exceed 1/2 the length of the rectangle Placement: should bisect left side of the rectangle at approximately a right angle and intersect the diagonal cross</td>
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<tr>
<td>4. circle</td>
<td></td>
<td></td>
<td></td>
<td>Drawing: round, unbroken and closed; diameter should be approximately 1/4–1/3 height of rectangle Placement: placed in appropriate segment; not touching any other part of figure</td>
</tr>
<tr>
<td>5. 3 small circles</td>
<td></td>
<td></td>
<td></td>
<td>Drawing: round, unbroken and closed; equal size; triangular arrangement; not touching each other Placement: in appropriate segment; not touching any other part of figure; triangle formed not rotated more than 15 degrees</td>
</tr>
<tr>
<td>6. square</td>
<td></td>
<td></td>
<td></td>
<td>Drawing: must be closed; 90 degree angles; lines straight and unbroken; height is 1/4–1/3 height of rectangle Placement: in appropriate segment; not touching any other part of figure; not rotated more than 15 degrees</td>
</tr>
<tr>
<td>7. curving line</td>
<td></td>
<td></td>
<td></td>
<td>Drawing: 2 curved segments are approximately equal in length and symmetrical; correct direction of curves Placement: ends of line touch diagonal; do not touch corner of rectangle or intersection of diagonal lines</td>
</tr>
<tr>
<td>8. outside cross</td>
<td></td>
<td></td>
<td></td>
<td>Drawing: vertical line of the outside cross is parallel to side of rectangle; &gt;1/2 the height of rectangle; horizontal line crosses vertical at 90 degree angle and is between 20–50% of length of vertical line Placement: horizontal line of outside cross touches rectangle higher than 2/3 the height of rectangle, but below top; does not penetrate the rectangle</td>
</tr>
<tr>
<td>9. triangle</td>
<td></td>
<td></td>
<td></td>
<td>Drawing: angle formed by 2 sides of triangle is between 60–100 degrees; sides are straight, unbroken and meet in a point; distance on vertical side of rectangle subsumed by triangle is approximately 50% of the height of vertical side Placement: roughly centered on the left vertical side of the rectangle</td>
</tr>
<tr>
<td>10. arrow</td>
<td></td>
<td></td>
<td></td>
<td>Drawing: straight and unbroken; lines forming arrow are approximately equal in length and not more than 1/3 length of staff Placement: must protrude from appropriate corner of rectangle such that staff appears to be continuation of diagonal cross</td>
</tr>
</tbody>
</table>

**Total Score**
**Range:** 0–2.0
Figure Recall Drawing Page
(Fold back for use.)
## Supplemental Discrepancy Analysis Page

### Index Differences

<table>
<thead>
<tr>
<th>Score 1–Score 2</th>
<th>Score 1</th>
<th>Score 2</th>
<th>Difference</th>
<th>Statistical Significance Level</th>
<th>Frequency of Difference in Standardization Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate Memory—Visuospatial/Constructional</td>
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<td>Language—Total Scale</td>
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<td>Delayed Memory—Total Scale</td>
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</tbody>
</table>
I. Immediate Memory

1. List Learning
   ![Diagram](image1)
   ![Diagram](image2)

2. Story Memory
   ![Diagram](image3)
   ![Diagram](image4)

II. Visuospatial/Constructional

3. Figure Copy
   ![Diagram](image5)
   ![Diagram](image6)

4. Line Orientation
   ![Diagram](image7)
   ![Diagram](image8)

III. Language

5. Picture Naming
   ![Diagram](image9)
   ![Diagram](image10)

6. Semantic Fluency
   ![Diagram](image11)
   ![Diagram](image12)

IV. Attention

7. Digit Span
   ![Diagram](image13)
   ![Diagram](image14)

8. Coding
   ![Diagram](image15)

V. Delayed Memory

9. List Recall
   ![Diagram](image16)
   ![Diagram](image17)

10. List Recognition
    ![Diagram](image18)
    ![Diagram](image19)

11. Story Recall
    ![Diagram](image20)
    ![Diagram](image21)

12. Figure Recall
    ![Diagram](image22)
    ![Diagram](image23)

   Sum of Total Scores for Subtests 9 + 11 + 12 =

---

**Note.** Use Appendix 2 in the Stimulus Booklet to convert Total Scores to Index Scores and Sum of Index Scores to Total Scale. Subtest scaled scores and cumulative percentages are also available.

**Sum of Index Scores**
(light-colored boxes)

**TOTAL SCALE**
National Center for PTSD

CLINICIAN-ADMINISTERED PTSD SCALE FOR DSM-5
PAST MONTH VERSION

Subject ID: _______________________________  ID#:  __________________
Interviewer: _______________________________  Date:  __________________
Study: _______________________________

Frank W. Weathers, Dudley D. Blake, Paula P. Schnurr,
Danny G. Kaloupek, Brian P. Marx, & Terence M. Keane

National Center for Posttraumatic Stress Disorder
October 28, 2013
Instructions

Standard administration and scoring of the CAPS-5 are essential for producing reliable and valid scores and diagnostic decisions. The CAPS-5 should be administered only by qualified interviewers who have formal training in structured clinical interviewing and differential diagnosis, a thorough understanding of the conceptual basis of PTSD and its various symptoms, and detailed knowledge of the features and conventions of the CAPS-5 itself.

Administration

1. Identify an index traumatic event to serve as the basis for symptom inquiry. Administer the Life Events Checklist and Criterion A inquiry provided on p. 5, or use some other structured, evidence-based method. The index event may involve either a single incident (e.g., “the accident”) or multiple, closely related incidents (e.g., “the worst parts of your combat experiences”).

2. Read prompts verbatim, one at a time, and in the order presented, EXCEPT:
   a. Use the respondent’s own words for labeling the index event or describing specific symptoms.
   b. Rephrase standard prompts to acknowledge previously reported information, but return to verbatim phrasing as soon as possible. For example, inquiry for item 20 might begin: “You already mentioned having problems sleeping. What kinds of problems?”
   c. If you don’t have sufficient information after exhausting all standard prompts, follow up ad lib. In this situation, repeating the initial prompt often helps refocus the respondent.
   d. As needed, ask for specific examples or direct the respondent to elaborate even when such prompts are not provided explicitly.

3. In general, DO NOT suggest responses. If a respondent has pronounced difficulty understanding a prompt it may be necessary to offer a brief example to clarify and illustrate. However, this should be done rarely and only after the respondent has been given ample opportunity to answer spontaneously.

4. DO NOT read rating scale anchors to the respondent. They are intended only for you, the interviewer, because appropriate use requires clinical judgment and a thorough understanding of CAPS-5 scoring conventions.

5. Move through the interview as efficiently as possible to minimize respondent burden. Some useful strategies:
   a. Be thoroughly familiar with the CAPS-5 so that prompts flow smoothly.
   b. Ask the fewest number of prompts needed to obtain sufficient information to support a valid rating.
   c. Minimize note-taking and write while the respondent is talking to avoid long pauses.
   d. Take charge of the interview. Be respectful but firm in keeping the respondent on task, transitioning between questions, pressing for examples, or pointing out contradictions.

Scoring

1. As with previous versions of the CAPS, CAPS-5 symptom severity ratings are based on symptom frequency and intensity, except for items 8 (amnesia) and 12 (diminished interest), which are based on amount and intensity. However, CAPS-5 items are rated with a single severity score, in contrast to previous versions of the CAPS which required separate frequency and intensity scores for each item that were either summed to create a symptom severity score or combined in various scoring rules to create a dichotomous (present/absent) symptom score. Thus, on the
CAPS-5 the clinician combines information about frequency and intensity before making a single severity rating. Depending on the item, frequency is rated as either the number of occurrences (how often in the past month) or percent of time (how much of the time in the past month). Intensity is rated on a four-point ordinal scale with ratings of Minimal, Clearly Present, Pronounced, and Extreme. Intensity and severity are related but distinct. Intensity refers to the strength of a typical occurrence of a symptom. Severity refers to the total symptom load over a given time period, and is a combination of intensity and frequency. This is similar to the quantity/frequency assessment approach to alcohol consumption. In general, intensity rating anchors correspond to severity scale anchors described below and should be interpreted and used in the same way, except that severity ratings require joint consideration of intensity and frequency. Thus, before taking frequency into account, an intensity rating of Minimal corresponds to a severity rating of Mild / subthreshold, Clearly Present corresponds with Moderate / threshold, Pronounced corresponds with Severe / markedly elevated, and Extreme corresponds with Extreme / incapacitating.

2. The five-point CAPS-5 symptom severity rating scale is used for all symptoms. Rating scale anchors should be interpreted and used as follows:

0 Absent The respondent denied the problem or the respondent’s report doesn’t fit the DSM-5 symptom criterion.  
1 Mild / subthreshold The respondent described a problem that is consistent with the symptom criterion but isn’t severe enough to be considered clinically significant. The problem doesn’t satisfy the DSM-5 symptom criterion and thus doesn’t count toward a PTSD diagnosis.  
2 Moderate / threshold The respondent described a clinically significant problem. The problem satisfies the DSM-5 symptom criterion and thus counts toward a PTSD diagnosis. The problem would be a target for intervention. This rating requires a minimum frequency of 2 X month or some of the time (20-30%) PLUS a minimum intensity of Clearly Present.  
3 Severe / markedly elevated The respondent described a problem that is well above threshold. The problem is difficult to manage and at times overwhelming, and would be a prominent target for intervention. This rating requires a minimum frequency of 2 X week or much of the time (50-60%) PLUS a minimum intensity of Pronounced.  
4 Extreme / incapacitating The respondent described a dramatic symptom, far above threshold. The problem is pervasive, unmanageable, and overwhelming, and would be a high-priority target for intervention.

3. In general, make a given severity rating only if the minimum frequency and intensity for that rating are both met. However, you may exercise clinical judgment in making a given severity rating if the reported frequency is somewhat lower than required, but the intensity is higher. For example, you may make a severity rating of Moderate / threshold if a symptom occurs 1 X month (instead of the required 2 X month) as long as the intensity is rated Pronounced or Extreme (instead of the required Clearly Present). Similarly, you may make a severity rating of Severe / markedly elevated if a symptom occurs 1 X week (instead of the required 2 X week) as long as the intensity is rated Extreme (instead of the required Pronounced). If you are unable to decide between two severity ratings, make the lower rating.

4. You need to establish that a symptom not only meets the DSM-5 criterion phenomenologically, but is also functionally related to the index traumatic event, i.e., started or got worse as a result of the event. CAPS-5 items 1-8 and 10 (reexperiencing, effortful avoidance, amnesia, and blame) are inherently linked to the event. Evaluate the remaining items for trauma-relatedness (TR) using the TR inquiry and rating scale. The three TR ratings are:

a. Definite = the symptom can clearly be attributed to the index trauma, because (1) there is an obvious change from the pre-trauma level of functioning and/or (2) the respondent makes the attribution to the index trauma with confidence.  
b. Probable = the symptom is likely related to the index trauma, but an unequivocal connection can’t be made. Situations in which this rating would be given include the following: (1) there seems to be a change from the pre-
trauma level of functioning, but it isn't as clear and explicit as it would be for a "definite;" (2) the respondent attributes a causal link between the symptom and the index trauma, but with less confidence than for a rating of Definite; (3) there appears to be a functional relationship between the symptom and inherently trauma-linked symptoms such as reexperiencing symptoms (e.g., numbing or withdrawal increases when reexperiencing increases).

c. **Unlikely** = the symptom can be attributed to a cause other than the index trauma because (1) there is an obvious functional link with this other cause and/or (2) the respondent makes a confident attribution to this other cause and denies a link to the index trauma. Because it can be difficult to rule out a functional link between a symptom and the index trauma, a rating of Unlikely should be used only when the available evidence strongly points to a cause other than the index trauma. NOTE: Symptoms with a TR rating of Unlikely should not be counted toward a PTSD diagnosis or included in the total CAPS-5 symptom severity score.

5. **CAPS-5 total symptom severity score** is calculated by summing severity scores for items 1-20. NOTE: Severity scores for the two dissociation items (29 and 30) should NOT be included in the calculation of the total CAPS-5 severity score.

6. **CAPS-5 symptom cluster severity scores** are calculated by summing the individual item severity scores for symptoms contained in a given DSM-5 cluster. Thus, the Criterion B (reexperiencing) severity score is the sum of the individual severity scores for items 1-5; the Criterion C (avoidance) severity score is the sum of items 6 and 7; the Criterion D (negative alterations in cognitions and mood) severity score is the sum of items 8-14; and the Criterion E (hyperarousal) severity score is the sum of items 15-20. A symptom cluster score may also be calculated for dissociation by summing items 29 and 30.

7. **PTSD diagnostic status** is determined by first dichotomizing individual symptoms as “present” or “absent,” then following the DSM-5 diagnostic rule. A symptom is considered present only if the corresponding item severity score is rated 2=Moderate/threshold or higher. Items 9 and 11-20 have the additional requirement of a trauma-relatedness rating of Definite or Probable. Otherwise a symptom is considered absent. The DSM-5 diagnostic rule requires the presence of at least one Criterion B symptom, one Criterion C symptom, two Criterion D symptoms, and two Criterion E symptoms. In addition, Criteria F and G must be met. Criterion F requires that the disturbance has lasted at least one month. Criterion G requires that the disturbance cause either clinically significant distress or functional impairment, as indicated by a rating of 2=moderate or higher on items 23-25.
Criterion A: Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others.
3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse). Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

[Administer Life Events Checklist or other structured trauma screen]

I'm going to ask you about the stressful experiences questionnaire you filled out. First I'll ask you to tell me a little bit about the event you said was the worst for you. Then I'll ask how that event may have affected you over the past month. In general I don't need a lot of information – just enough so I can understand any problems you may have had. Please let me know if you find yourself becoming upset as we go through the questions so we can slow down and talk about it. Also, let me know if you have any questions or don't understand something. Do you have any questions before we start?

The event you said was the worst was (EVENT). What I'd like for you to do is briefly describe what happened.

Index event (specify):

<table>
<thead>
<tr>
<th>What happened? (How old were you? How were you involved? Who else was involved? Was anyone seriously injured or killed? Was anyone's life in danger? How many times did this happen?)</th>
<th>Exposure type:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experienced ___</td>
<td>Witnessed ___</td>
</tr>
<tr>
<td>Learned about ___</td>
<td>Exposed to aversive details___</td>
</tr>
<tr>
<td>Life threat?</td>
<td>NO YES [self ___ other ___]</td>
</tr>
<tr>
<td>Serious injury?</td>
<td>NO YES [self ___ other ___]</td>
</tr>
<tr>
<td>Sexual violence?</td>
<td>NO YES [self ___ other ___]</td>
</tr>
<tr>
<td>Criterion A met?</td>
<td>NO PROBABLE YES</td>
</tr>
</tbody>
</table>

For the rest of the interview, I want you to keep (EVENT) in mind as I ask you about different problems it may have caused you. You may have had some of these problems before, but for this interview we're going to focus just on the past month. For each problem I'll ask if you've had it in the past month, and if so, how often and how much it bothered you.
Criterion B: Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

1. (B1) Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). Note: In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.

| In the past month, have you had any unwanted memories of (EVENT) while you were awake, so not counting dreams? | 0 Absent  
|                                                                                                                | 1 Mild / subthreshold  
| How does it happen that you start remembering (EVENT)? | 2 Moderate / threshold  
| (Are these unwanted memories, or are you thinking about [EVENT] on purpose?) | 3 Severe / markedly elevated  
| How much do these memories bother you? | 4 Extreme / incapacitating  
| Are you able to put them out of your mind and think about something else? |  
| Circle: Distress = Minimal Clearly Present Pronounced Extreme |  
| How often have you had these memories in the past month? | # of times __________  

Key rating dimensions = frequency / intensity of distress
Moderate = at least 2 X month / distress clearly present, some difficulty dismissing memories  
Severe = at least 2 X week / pronounced distress, considerable difficulty dismissing memories

2. (B2) Recurrent distressing dreams in which the content and/or affect of the dream are related to the event(s). Note: In children, there may be frightening dreams without recognizable content.

| In the past month, have you had any unpleasant dreams about (EVENT)? | 0 Absent  
| Describe a typical dream. (What happens?) | 1 Mild / subthreshold  
| (Do they wake you up?) | 2 Moderate / threshold  
| (What do you experience when you wake up? How long does it take you to get back to sleep?) | 3 Severe / markedly elevated  
| (How much sleep do you lose?) | 4 Extreme / incapacitating  
| How much do these dreams bother you? |  
| Circle: Distress = Minimal Clearly Present Pronounced Extreme |  
| How often have you had these dreams in the past month? | # of times __________  

Key rating dimensions = frequency / intensity of distress
Moderate = at least 2 X month / distress clearly present, less than 1 hour sleep loss  
Severe = at least 2 X week / pronounced distress, more than 1 hour sleep loss

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3. (B3) Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) Note: In children, trauma-specific reenactment may occur in play.

<table>
<thead>
<tr>
<th>In the past month, have there been times when you suddenly acted or felt as if (EVENT) were actually happening again?</th>
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<tbody>
<tr>
<td>[If not clear:] (This is different than thinking about it or dreaming about it – now I’m asking about flashbacks, when you feel like you’re actually back at the time of [EVENT], actually reliving it.)</td>
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<tr>
<td>How much does it seem as if (EVENT) were happening again? (Are you confused about where you actually are?)</td>
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<tr>
<td>What do you do while this is happening? (Do other people notice your behavior? What do they say?)</td>
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<tr>
<td>How long does it last?</td>
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<tr>
<td>Circle: Dissociation = Minimal    Clearly Present    Pronounced    Extreme</td>
</tr>
<tr>
<td>How often has this happened in the past month? # of times __________</td>
</tr>
</tbody>
</table>

**Key rating dimensions = frequency / intensity of dissociation**

- Moderate = at least 2 X month / dissociative quality clearly present, may retain some awareness of surroundings but relives event in a manner clearly distinct from thoughts and memories
- Severe = at least 2 X week / pronounced dissociative quality, reports vivid reliving, e.g., with images, sounds, smells

4. (B4) Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

<table>
<thead>
<tr>
<th>In the past month, have you gotten emotionally upset when something reminded you of (EVENT)?</th>
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<tr>
<td>What kinds of reminders make you upset?</td>
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<tr>
<td>How much do these reminders bother you?</td>
</tr>
<tr>
<td>Are you able to calm yourself down when this happens? (How long does it take?)</td>
</tr>
<tr>
<td>Circle: Distress = Minimal    Clearly Present    Pronounced    Extreme</td>
</tr>
<tr>
<td>How often has this happened in the past month? # of times __________</td>
</tr>
</tbody>
</table>

**Key rating dimensions = frequency / intensity of distress**

- Moderate = at least 2 X month / distress clearly present, some difficulty recovering
- Severe = at least 2 X week / pronounced distress, considerable difficulty recovering
5. (B5) Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

In the past month, have you had any **physical reactions** when something reminded you of (EVENT)?

Can you give me some examples? *(Does your heart race or your breathing change? What about sweating or feeling really tense or shaky?)*

What kinds of reminders trigger these reactions?

How long does it take you to recover?

*Circle: Physiological reactivity = Minimal  Clearly Present  Pronounced  Extreme*

How often has this happened in the past month?  # of times _________

*Key rating dimensions = frequency / intensity of physiological arousal*

Moderate = at least 2 X month / reactivity clearly present, some difficulty recovering

Severe = at least 2 X week / pronounced reactivity, sustained arousal, considerable difficulty recovering

---

**Criterion C: Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:**

6. (C1) Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

In the past month, have you tried to **avoid thoughts or feelings** about (EVENT)?

What kinds of thoughts or feelings do you avoid?

How hard do you try to avoid these thoughts or feelings? *(What kinds of things do you do?)*

*Circle: Avoidance = Minimal  Clearly Present  Pronounced  Extreme*

How often in the past month?  # of times _________

*Key rating dimensions = frequency / intensity of avoidance*

Moderate = at least 2 X month / avoidance clearly present

Severe = at least 2 X week / pronounced avoidance
7. (C2) Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

In the past month, have you tried to avoid things that remind you of (EVENT), like certain people, places, or situations?

What kinds of things do you avoid?

How much effort do you make to avoid these reminders? (Do you have to make a plan or change your activities to avoid them?)

[If not clear:] (Overall, how much of a problem is this for you? How would things be different if you didn’t have to avoid these reminders?)

Circle: Avoidance = Minimal  Clearly Present  Pronounced  Extreme

How often in the past month?  # of times __________

Key rating dimensions = frequency / intensity of avoidance
Moderate = at least 2 X month / avoidance clearly present
Severe = at least 2 X week / pronounced avoidance

Criterion D: Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

8. (D1) Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).

In the past month, have you had difficulty remembering some important parts of (EVENT)? (Do you feel there are gaps in your memory of [EVENT]?)

What parts have you had difficulty remembering?

Do you feel you should be able to remember these things?

[If not clear:] (Why do you think you can’t? Did you have a head injury during [EVENT]? Were you knocked unconscious? Were you intoxicated from alcohol or drugs?) [Rate 0=Absent if due to head injury or loss of consciousness or intoxication during event]

[If still not clear:] (Is this just normal forgetting? Or do you think you may have blocked it out because it would be too painful to remember?) [Rate 0=Absent if due only to normal forgetting]

Circle: Difficulty remembering = Minimal  Clearly Present  Pronounced  Extreme

In the past month, how many of the important parts of (EVENT) have you had difficulty remembering? (What parts do you still remember?)  # of important aspects __________

Would you be able to recall these things if you tried?

Key rating dimensions = amount of event not recalled / intensity of inability to recall
Moderate = at least one important aspect / difficulty remembering clearly present, some recall possible with effort
Severe = several important aspects / pronounced difficulty remembering, little recall even with effort
9. (D2) Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., “I am bad,” “No one can be trusted,” “The world is completely dangerous,” “My whole nervous system is permanently ruined”).

<table>
<thead>
<tr>
<th>In the past month, have you had strong negative beliefs about yourself, other people, or the world?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Can you give me some examples?</strong> (What about believing things like “I am bad,” “there is something seriously wrong with me,” “no one can be trusted,” “the world is completely dangerous”?)</td>
</tr>
<tr>
<td><strong>How strong are these beliefs?</strong> (How convinced are you that these beliefs are actually true? Can you see other ways of thinking about it?)</td>
</tr>
<tr>
<td>Circle: Conviction = Minimal</td>
</tr>
<tr>
<td><strong>How much of the time in the past month have you felt that way?</strong> % of time</td>
</tr>
<tr>
<td><strong>Did these beliefs start or get worse after (EVENT)?</strong> (Do you think they’re related to [EVENT]? How so?) Circle: Trauma-relatedness = Definite</td>
</tr>
</tbody>
</table>

Key rating dimensions = frequency / intensity of beliefs
Moderate = some of the time (20-30%) / exaggerated negative expectations clearly present, some difficulty considering more realistic beliefs
Severe = much of the time (50-60%) / pronounced exaggerated negative expectations, considerable difficulty considering more realistic beliefs

10. (D3) Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.

<table>
<thead>
<tr>
<th>In the past month, have you blamed yourself for (EVENT) or what happened as a result of it? Tell me more about that. (In what sense do you see yourself as having caused [EVENT]? Is it because of something you did? Or something you think you should have done but didn’t? Is it because of something about you in general?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>What about blaming someone else for (EVENT) or what happened as a result of it? Tell me more about that. (In what sense do you see [OTHERS] as having caused [EVENT]? Is it because of something they did? Or something you think they should have done but didn’t?)</td>
</tr>
<tr>
<td><strong>How much do you blame (YOURSELF OR OTHERS)?</strong></td>
</tr>
<tr>
<td><strong>How convinced are you that [YOU OR OTHERS] are truly responsible for what happened?</strong> (Do other people agree with you? Can you see other ways of thinking about it?)</td>
</tr>
<tr>
<td>[Rate 0=Absent if only blames perpetrator, i.e., someone who deliberately caused the event and intended harm]</td>
</tr>
<tr>
<td>Circle: Conviction = Minimal</td>
</tr>
<tr>
<td><strong>How much of the time in the past month have you felt that way?</strong> % of time</td>
</tr>
</tbody>
</table>

Key rating dimensions = frequency / intensity of blame
Moderate = some of the time (20-30%) / distorted blame clearly present, some difficulty considering more realistic beliefs
Severe = much of the time (50-60%) / pronounced distorted blame, considerable difficulty considering more realistic beliefs
11. (D4) Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).

| In the past month, have you had any **strong negative feelings** such as fear, horror, anger, guilt, or shame? | 0 Absent  
| 1 Mild / subthreshold  
| 2 Moderate / threshold  
| 3 Severe / markedly elevated  
| 4 Extreme / incapacitating |

| Can you give me some examples? (What negative feelings do you experience?) |
| How strong are these negative feelings? |
| How well are you able to manage them? |

Circle: Negative emotions = Minimal  Clearly Present  Pronounced  Extreme

| How much of the time in the past month have you felt that way?  |  % of time __________ |

| Did these negative feelings start or get worse after (EVENT)? (Do you think they’re related to [EVENT]? How so?) |

| Circle: Trauma-relatedness = Definite  Probable  Unlikely |

**Key rating dimensions** = frequency / intensity of negative emotions
Moderate = some of the time (20-30%) / negative emotions clearly present, some difficulty managing
Severe = much of the time (50-60%) / pronounced negative emotions, considerable difficulty managing

12. (D5) Markedly diminished interest or participation in significant activities.

| In the past month, have you been **less interested** in **activities** that you used to enjoy? |

| What kinds of things have you lost interest in or don’t do as much as you used to? (Anything else?) |
| Why is that? [Rate 0=Absent if diminished participation is due to lack of opportunity, physical inability, or developmentally appropriate change in preferred activities] |
| How strong is your loss of interest? (Would you still enjoy [ACTIVITIES] once you got started?) |

Circle: Loss of interest= Minimal  Clearly Present  Pronounced  Extreme

| Overall, in the past month, how many of your usual activities have you been less interested in?  |  % of activities __________ |

| What kinds of things do you still enjoy doing? |
| Did this loss of interest start or get worse after (EVENT)? (Do you think it’s related to [EVENT]? How so?) |

| Circle: Trauma-relatedness = Definite  Probable  Unlikely |

**Key rating dimensions** = percent of activities affected / intensity of loss of interest
Moderate = some activities (20-30%) / loss of interest clearly present but still has some enjoyment of activities
Severe = many activities (50-60%) / pronounced loss of interest, little interest or participation in activities
**13. (D6) Feelings of detachment or estrangement from others.**

| In the past month, have you felt distant or cut off from other people? | 0 Absent  
| Tell me more about that. | 1 Mild / subthreshold  
| How strong are your feelings of being distant or cut off from others? (Who do you feel closest to? How many people do you feel comfortable talking with about personal things?) | 2 Moderate / threshold  
| Circle: Detachment or estrangement = Minimal Clearly Present Pronounced Extreme | 3 Severe / markedly elevated  
| How much of the time in the past month have you felt that way? % of time ________ | 4 Extreme / incapacitating  
| Did this feeling of being distant or cut off start or get worse after (EVENT)? (Do you think it's related to [EVENT]? How so?) |  
| Circle: Trauma-relatedness = Definite Probable Unlikely |  

**Key rating dimensions = frequency / intensity of detachment or estrangement**

- Moderate = some of the time (20-30%) / feelings of detachment clearly present but still feels some interpersonal connection
- Severe = much of the time (50-60%) / pronounced feelings of detachment or estrangement from most people, may feel close to only one or two people

---

**14. (D7) Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).**

| In the past month, have there been times when you had difficulty experiencing positive feelings like love or happiness? | 0 Absent  
| Tell me more about that. (What feelings are difficult to experience?) | 1 Mild / subthreshold  
| How much difficulty do you have experiencing positive feelings? (Are you still able to experience any positive feelings?) | 2 Moderate / threshold  
| Circle: Reduction of positive emotions = Minimal Clearly Present Pronounced Extreme | 3 Severe / markedly elevated  
| How much of the time in the past month have you felt that way? % of time ________ | 4 Extreme / incapacitating  
| Did this trouble experiencing positive feelings start or get worse after (EVENT)? (Do you think it's related to [EVENT]? How so?) |  
| Circle: Trauma-relatedness = Definite Probable Unlikely |  

**Key rating dimensions = frequency / intensity of reduction in positive emotions**

- Moderate = some of the time (20-30%) / reduction of positive emotional experience clearly present but still able to experience some positive emotions
- Severe = much of the time (50-60%) / pronounced reduction of experience across range of positive emotions
Criterion E: Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

15. (E1) Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.

<table>
<thead>
<tr>
<th>In the past month, have there been times when you felt especially irritable or angry and showed it in your behavior?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Can you give me some examples?</strong> <em>(How do you show it? Do you raise your voice or yell? Throw or hit things? Push or hit other people?)</em></td>
</tr>
<tr>
<td><strong>Circle:</strong> Aggression = Minimal</td>
</tr>
<tr>
<td><strong>How often in the past month?</strong></td>
</tr>
<tr>
<td><strong>Did this behavior start or get worse after (EVENT)?</strong> <em>(Do you think it’s related to [EVENT]??)</em></td>
</tr>
<tr>
<td><strong>Circle:</strong> Trauma-relatedness = Definite</td>
</tr>
</tbody>
</table>

*Key rating dimensions = frequency / intensity of aggressive behavior*
Moderate = at least 2 X month / aggression clearly present, primarily verbal
Severe = at least 2 X week / pronounced aggression, at least some physical aggression

16. (E2) Reckless or self-destructive behavior.

<table>
<thead>
<tr>
<th>In the past month, have there been times when you were taking more risks or doing things that might have caused you harm?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Can you give me some examples?</strong></td>
</tr>
<tr>
<td><strong>How much of a risk do you take?</strong> <em>(How dangerous are these behaviors? Were you injured or harmed in some way?)</em></td>
</tr>
<tr>
<td><strong>Circle:</strong> Risk = Minimal</td>
</tr>
<tr>
<td><strong>How often have you taken these kinds of risks in the past month?</strong></td>
</tr>
<tr>
<td><strong>Did this behavior start or get worse after (EVENT)?</strong> <em>(Do you think it’s related to [EVENT]??)</em></td>
</tr>
<tr>
<td><strong>Circle:</strong> Trauma-relatedness = Definite</td>
</tr>
</tbody>
</table>

*Key rating dimensions = frequency / degree of risk*
Moderate = at least 2 X month / risk clearly present, may have been harmed
Severe = at least 2 X week / pronounced risk, actual harm or high probability of harm
17. (E3) Hypervigilance.

In the past month, have you been especially alert or watchful, even when there was no specific threat or danger?  *(Have you felt as if you had to be on guard?)*

Can you give me some examples? *(What kinds of things do you do when you’re alert or watchful?)*

[If not clear:] *(What causes you to react this way? Do you feel like you’re in danger or threatened in some way? Do you feel that way more than most people would in the same situation?)*

Circle: Hypervigilance = Minimal  Clearly Present  Pronounced  Extreme

How much of the time in the past month have you felt that way?  % of time ______

Did being especially alert or watchful start or get worse after (EVENT)? *(Do you think it’s related to [EVENT]? How so?)*  Circle: Trauma-relatedness = Definite  Probable  Unlikely

Key rating dimensions = frequency / intensity of hypervigilance
Moderate = some of the time (20-30%) / hypervigilance clearly present, e.g., watchful in public, heightened awareness of threat
Severe = much of the time (50-60%) / pronounced hypervigilance, e.g., scans environment for danger, may have safety rituals, exaggerated concern for safety of self/family/home

18. (E4) Exaggerated startle response.

In the past month, have you had any strong startle reactions?

What kinds of things made you startle?

How strong are these startle reactions? *(How strong are they compared to how most people would respond? Do you do anything other people would notice?)*

How long does it take you to recover?

Circle: Startle = Minimal  Clearly Present  Pronounced  Extreme

How often has this happened in the past month?  # of times ______

Did these startle reactions start or get worse after (EVENT)? *(Do you think they’re related to [EVENT]? How so?)*  Circle: Trauma-relatedness = Definite  Probable  Unlikely

Key rating dimensions = frequency / intensity of startle
Moderate = at least 2 X month / startle clearly present, some difficulty recovering
Severe = at least 2 X week / pronounced startle, sustained arousal, considerable difficulty recovering
19. (E5) Problems with concentration.

<table>
<thead>
<tr>
<th>In the past month, have you had any problems with concentration?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can you give me some examples?</td>
</tr>
<tr>
<td>Are you able to concentrate if you really try?</td>
</tr>
<tr>
<td>Circle: Problem concentrating = Minimal  Clearly Present  Pronounced  Extreme</td>
</tr>
<tr>
<td>How much of the time in the past month have you had problems with concentration?</td>
</tr>
<tr>
<td>% of time _________</td>
</tr>
<tr>
<td>Did these problems with concentration start or get worse after (EVENT)?  (Do you think they’re related to [EVENT]? How so?)</td>
</tr>
<tr>
<td>Circle: Trauma-relatedness = Definite  Probable  Unlikely</td>
</tr>
</tbody>
</table>

**Key rating dimensions = frequency / intensity of concentration problems**
- Moderate = some of the time (20-30%) / problem concentrating clearly present, some difficulty but can concentrate with effort
- Severe = much of the time (50-60%) / pronounced problem concentrating, considerable difficulty even with effort

20. (E6) Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

<table>
<thead>
<tr>
<th>In the past month, have you had any problems falling or staying asleep?</th>
</tr>
</thead>
<tbody>
<tr>
<td>What kinds of problems? (How long does it take you to fall asleep? How often do you wake up in the night? Do you wake up earlier than you want to?)</td>
</tr>
<tr>
<td>How many total hours do you sleep each night?</td>
</tr>
<tr>
<td>How many hours do you think you should be sleeping?</td>
</tr>
<tr>
<td>Circle: Problem sleeping = Minimal  Clearly Present  Pronounced  Extreme</td>
</tr>
<tr>
<td>How often in the past month have you had these sleep problems?  # of times _________</td>
</tr>
<tr>
<td>Did these sleep problems start or get worse after (EVENT)?  (Do you think they’re related to [EVENT]? How so?)</td>
</tr>
<tr>
<td>Circle: Trauma-relatedness = Definite  Probable  Unlikely</td>
</tr>
</tbody>
</table>

**Key rating dimensions = frequency / intensity of sleep problems**
- Moderate = at least 2 X month / sleep disturbance clearly present, clearly longer latency or clear difficulty staying asleep, 30-90 minutes loss of sleep
- Severe = at least 2 X week / pronounced sleep disturbance, considerably longer latency or marked difficulty staying asleep, 90 min to 3 hrs loss of sleep
### Criterion F: Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.

21. Onset of symptoms

<table>
<thead>
<tr>
<th>[If not clear:] When did you first start having (PTSD SYMPTOMS) you’ve told me about? (How long after the trauma did they start? More than six months?)</th>
<th>Total # months delay in onset ________</th>
</tr>
</thead>
<tbody>
<tr>
<td>With delayed onset (≥ 6 months)? NO YES</td>
<td></td>
</tr>
</tbody>
</table>

| Total # months duration ________ |
| Duration more than 1 month? NO YES |

### Criterion G: The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

22. Duration of symptoms

| [If not clear:] How long have these (PTSD SYMPTOMS) lasted altogether? |
| Total # months duration ________ |
| Duration more than 1 month? NO YES |

23. Subjective distress

| Overall, in the past month, how much have you been bothered by these (PTSD SYMPTOMS) you’ve told me about? [Consider distress reported on earlier items] |
| 0 None |
| 1 Mild, minimal distress |
| 2 Moderate, distress clearly present but still manageable |
| 3 Severe, considerable distress |
| 4 Extreme, incapacitating distress |

24. Impairment in social functioning

| In the past month, have these (PTSD SYMPTOMS) affected your relationships with other people? How so? [Consider impairment in social functioning reported on earlier items] |
| 0 No adverse impact |
| 1 Mild impact, minimal impairment in social functioning |
| 2 Moderate impact, definite impairment but many aspects of social functioning still intact |
| 3 Severe impact, marked impairment, few aspects of social functioning still intact |
| 4 Extreme impact, little or no social functioning |

25. Impairment in occupational or other important area of functioning

| [If not clear:] Are you working now? |
| [If yes:] In the past month, have these (PTSD SYMPTOMS) affected your work or your ability to work? How so? [Consider reported work history, including number and duration of jobs, as well as the quality of work relationships. If premorbid functioning is unclear, inquire about work experiences before the trauma. For child/adolescent trauma, assess pre-trauma school performance and possible presence of behavior problems] |
| 0 No adverse impact |
| 1 Mild impact, minimal impairment in occupational/other important functioning |
| 2 Moderate impact, definite impairment but many aspects of occupational/other important functioning still intact |
| 3 Severe impact, marked impairment, few aspects of occupational/other important functioning still intact |
| 4 Extreme impact, little or no occupational/other important functioning |

[If no:] Have these (PTSD SYMPTOMS) affected any other important part of your life? [As appropriate, suggest examples such as parenting, housework, schoolwork, volunteer work, etc.] How so?
### Global Ratings

#### 26. Global validity

Estimate the overall validity of responses. Consider factors such as compliance with the interview, mental status (e.g., problems with concentration, comprehension of items, dissociation), and evidence of efforts to exaggerate or minimize symptoms.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Excellent, no reason to suspect invalid responses</td>
</tr>
<tr>
<td>1</td>
<td>Good, factors present that may adversely affect validity</td>
</tr>
<tr>
<td>2</td>
<td>Fair, factors present that definitely reduce validity</td>
</tr>
<tr>
<td>3</td>
<td>Poor, substantially reduced validity</td>
</tr>
<tr>
<td>4</td>
<td>Invalid responses, severely impaired mental status or possible deliberate “faking bad” or “faking good”</td>
</tr>
</tbody>
</table>

#### 27. Global severity

Estimate the overall severity of PTSD symptoms. Consider degree of subjective distress, degree of functional impairment, observations of behaviors in interview, and judgment regarding reporting style.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No clinically significant symptoms, no distress and no functional impairment</td>
</tr>
<tr>
<td>1</td>
<td>Mild, minimal distress or functional impairment</td>
</tr>
<tr>
<td>2</td>
<td>Moderate, definite distress or functional impairment but functions satisfactorily with effort</td>
</tr>
<tr>
<td>3</td>
<td>Severe, considerable distress or functional impairment, limited functioning even with effort</td>
</tr>
<tr>
<td>4</td>
<td>Extreme, marked distress or marked impairment in two or more major areas of functioning</td>
</tr>
</tbody>
</table>

#### 28. Global improvement

Rate total overall improvement since the previous rating. Rate the degree of change, whether or not, in your judgment, it is due to treatment.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Asymptomatic</td>
</tr>
<tr>
<td>1</td>
<td>Considerable improvement</td>
</tr>
<tr>
<td>2</td>
<td>Moderate improvement</td>
</tr>
<tr>
<td>3</td>
<td>Slight improvement</td>
</tr>
<tr>
<td>4</td>
<td>No improvement</td>
</tr>
<tr>
<td>5</td>
<td>Insufficient information</td>
</tr>
</tbody>
</table>
Specify whether with dissociative symptoms: The individual’s symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

29. (1) Depersonalization: Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one’s mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).

In the past month, have there been times when you felt as if you were separated from yourself, like you were watching yourself from the outside or observing your thoughts and feelings as if you were another person?

[If no:] *(What about feeling as if you were in a dream, even though you were awake? Feeling as if something about you wasn’t real? Feeling as if time was moving more slowly?)*

Tell me more about that.

How strong is this feeling? *(Do you lose track of where you actually are or what’s actually going on?)*

What do you do while this is happening? *(Do other people notice your behavior? What do they say?)*

How long does it last?

Circle: Dissociation = Minimal  Clearly Present  Pronounced  Extreme

[If not clear:] *(Was this due to the effects of alcohol or drugs? What about a medical condition like seizures?)* [Rate 0=Absent if due to the effects of a substance or another medical condition]

How often has this happened in the past month?  # of times __________

**Key rating dimensions = frequency / intensity of dissociation**

Moderate = at least 2 X month / dissociative quality clearly present but transient, retains some realistic sense of self and awareness of environment

Severe = at least 2 X week / pronounced dissociative quality, marked sense of detachment and unreality

0  Absent
1  Mild / subthreshold
2  Moderate / threshold
3  Severe / markedly elevated
4  Extreme / incapacitating
30. (2) Derealization: Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).

In the past month, have there been times when things going on around you seemed unreal or very strange and unfamiliar?

[If no:] (Do things going on around you seem like a dream or like a scene from a movie? Do they seem distant or distorted?)

Tell me more about that.

How strong is this feeling? (Do you lose track of where you actually are or what’s actually going on?)

What do you do while this is happening? (Do other people notice your behavior? What do they say?)

How long does it last?

Circle: Dissociation = Minimal Clearly Present Pronounced Extreme

[If not clear:] (Was this due to the effects of alcohol or drugs? What about a medical condition like seizures?) [Rate 0=Absent if due to the effects of a substance or another medical condition]

How often has this happened in the past month? # of times ________

Key rating dimensions = frequency / intensity of dissociation
Moderate = at least 2 X month / dissociative quality clearly present but transient, retains some realistic sense of environment
Severe = at least 2 X week / pronounced dissociative quality, marked sense of unreality
## CAPS-5 SUMMARY SHEET

**Name:** ____________________  **ID#:_____**  **Interviewer:** ____________________  **Study:** __________  **Date:** __________

### A. Exposure to actual or threatened death, serious injury, or sexual violence

**Criterion A met?**

<table>
<thead>
<tr>
<th>0 = NO</th>
<th>1 = YES</th>
</tr>
</thead>
</table>

### B. Intrusion symptoms (need 1 for diagnosis)

**Past Month**

<table>
<thead>
<tr>
<th>Sev</th>
<th>Sx (Sev ≥ 2)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) B1 – Intrusive memories</td>
<td>0 = NO 1 = YES</td>
</tr>
<tr>
<td>(2) B2 – Distressing dreams</td>
<td>0 = NO 1 = YES</td>
</tr>
<tr>
<td>(3) B3 – Dissociative reactions</td>
<td>0 = NO 1 = YES</td>
</tr>
<tr>
<td>(4) B4 – Cued psychological distress</td>
<td>0 = NO 1 = YES</td>
</tr>
<tr>
<td>(5) B5 – Cued physiological reactions</td>
<td>0 = NO 1 = YES</td>
</tr>
</tbody>
</table>

**B subtotals**

<table>
<thead>
<tr>
<th>B Sev</th>
<th># B Sx =</th>
</tr>
</thead>
</table>

### C. Avoidance symptoms (need 1 for diagnosis)

**Past Month**

<table>
<thead>
<tr>
<th>Sev</th>
<th>Sx (Sev ≥ 2)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>(6) C1 – Avoidance of memories, thoughts, feelings</td>
<td>0 = NO 1 = YES</td>
</tr>
<tr>
<td>(7) C2 – Avoidance of external reminders</td>
<td>0 = NO 1 = YES</td>
</tr>
</tbody>
</table>

**C subtotals**

<table>
<thead>
<tr>
<th>C Sev</th>
<th># C Sx =</th>
</tr>
</thead>
</table>

### D. Cognitions and mood symptoms (need 2 for diagnosis)

**Past Month**

<table>
<thead>
<tr>
<th>Sev</th>
<th>Sx (Sev ≥ 2)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>(8) D1 – Inability to recall important aspect of event</td>
<td>0 = NO 1 = YES</td>
</tr>
<tr>
<td>(9) D2 – Exaggerated negative beliefs or expectations</td>
<td>0 = NO 1 = YES</td>
</tr>
<tr>
<td>(10) D3 – Distorted cognitions leading to blame</td>
<td>0 = NO 1 = YES</td>
</tr>
<tr>
<td>(11) D4 – Persistent negative emotional state</td>
<td>0 = NO 1 = YES</td>
</tr>
<tr>
<td>(12) D5 – Diminished interest or participation in activities</td>
<td>0 = NO 1 = YES</td>
</tr>
<tr>
<td>(13) D6 – Detachment or estrangement from others</td>
<td>0 = NO 1 = YES</td>
</tr>
<tr>
<td>(14) D7 – Persistent inability to experience positive emotions</td>
<td>0 = NO 1 = YES</td>
</tr>
</tbody>
</table>

**D subtotals**

<table>
<thead>
<tr>
<th>D Sev</th>
<th># D Sx =</th>
</tr>
</thead>
</table>

### E. Arousal and reactivity symptoms (need 2 for diagnosis)

**Past Month**

<table>
<thead>
<tr>
<th>Sev</th>
<th>Sx (Sev ≥ 2)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>(15) E1 – Irritable behavior and angry outbursts</td>
<td>0 = NO 1 = YES</td>
</tr>
<tr>
<td>(16) E2 – Reckless or self-destructive behavior</td>
<td>0 = NO 1 = YES</td>
</tr>
<tr>
<td>(17) E3 – Hypervigilance</td>
<td>0 = NO 1 = YES</td>
</tr>
<tr>
<td>(18) E4 – Exaggerated startle response</td>
<td>0 = NO 1 = YES</td>
</tr>
<tr>
<td>(19) E5 – Problems with concentration</td>
<td>0 = NO 1 = YES</td>
</tr>
<tr>
<td>(20) E6 – Sleep disturbance</td>
<td>0 = NO 1 = YES</td>
</tr>
</tbody>
</table>

**E subtotals**

<table>
<thead>
<tr>
<th>E Sev</th>
<th># E Sx =</th>
</tr>
</thead>
</table>
## PTSD totals

<table>
<thead>
<tr>
<th>Past Month</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Sev</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Total # Sx</strong></td>
<td></td>
</tr>
</tbody>
</table>

### Sum of subtotals (B+C+D+E)

## F. Duration of disturbance

<table>
<thead>
<tr>
<th>Current</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 = NO</td>
</tr>
<tr>
<td>1 = YES</td>
</tr>
</tbody>
</table>

### (22) Duration of disturbance ≥ 1 month?

## G. Distress or impairment (need 1 for diagnosis)

<table>
<thead>
<tr>
<th>Sev</th>
<th>Cx (Sev &gt; 2)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 = NO</td>
<td>1 = YES</td>
</tr>
</tbody>
</table>

### (23) Subjective distress

### (24) Impairment in social functioning

### (25) Impairment in occupational functioning

### G subtotals

### G Sev = # G Cx =

## Global ratings

### (26) Global validity

### (27) Global severity

### (28) Global improvement

## Dissociative symptoms (need 1 for subtype)

<table>
<thead>
<tr>
<th>Sev</th>
<th>Sx (Sev &gt; 2)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 = NO</td>
<td>1 = YES</td>
</tr>
</tbody>
</table>

### (29) 1- Depersonalization

### (30) 2 – Derealization

### Dissociative subtotals

### Diss Sev = # Diss Sx =

## PTSD diagnosis

<table>
<thead>
<tr>
<th>Past Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 = NO</td>
</tr>
<tr>
<td>1 = YES</td>
</tr>
</tbody>
</table>

### PTSD PRESENT – ALL CRITERIA (A-G) MET?

### With dissociative symptoms

### (21) With delayed onset (≥ 6 months)

### With delayed onset (≥ 6 months)
**Balloon Analogue Risk Task**

**Inflate the Balloon by Pressing Key**

The BART presents participants with 30 virtual balloons.

- Each balloon can be inflated one increment for each key press.

**Balloon Grows in Size and Monetary Value**

- With each key press the size of the balloon increases.

- Each increment also increases the potential value of the balloon by 5 cents.

- The balloon can be “cashed in” at any time and the total accumulated value retained.

**If Balloon Explodes, All $$$ is Lost**

- Each Balloon can explode at any time.

- If a balloon explodes, all of the potential money accumulated for that balloon will be lost.

**Goal: Earn as Much Money as Possible**

- The goal is to maximize winnings

- Only 30 balloons are presented.
Curriculum Vitae

Date Prepared: October 4, 2014

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Work FAX: (617) 855-2770

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1985 A.A. (Liberal Arts), San Antonio College
1985 A.A.S (Radio-TV-Film), San Antonio College
1990 B.A. (Psychology), Summa cum laude with Distinction, University of New Mexico
1992 M.A. (Clinical Psychology), Texas Tech University
1996 PH.D. (Clinical Psychology), Texas Tech University

Postdoctoral Training
08/95-07/96 Predoctoral Fellow, Clinical Psychology, Yale School of Medicine
08/96-07/97 Postdoctoral Fellow, Clinical Neuropsychology, University of OK Health Sciences Center
08/97-09/99 Postdoctoral Fellow, Clinical Neuropsychology, University of Pennsylvania Medical School
07/99-09/00 Research Fellow, Neuroimaging, McLean Hospital/ Harvard Medical School
09/13-05/14 Certificate in Applied Biostatistics, Harvard Medical School

Faculty Academic Appointments
10/00-08/02 Instructor in Psychology in the Department of Psychiatry
Harvard Medical School, Boston, MA
09/02-07/07 Clinical Instructor in Psychology in the Department of Psychiatry
Harvard Medical School, Boston, MA
08/07-10/10 Instructor in Psychology in the Department of Psychiatry
Harvard Medical School, Boston, MA
04/08- Faculty Affiliate, Division of Sleep Medicine  
Harvard Medical School, Boston, MA
10/10-10/12 Assistant Professor of Psychology in the Department of Psychiatry  
Harvard Medical School, Boston, MA
10/12- Associate Professor of Psychology in the Department of Psychiatry  
Harvard Medical School

**Appointments at Hospitals/Affiliated Institutions**

10/00-08/02 Assistant Research Psychologist, McLean Hospital, Belmont, MA
08/02-07/04 Research Psychologist, Department of Behavioral Biology, Walter Reed Army Institute of Research, Silver Spring, MD
09/02-04/05 Special Volunteer, National Institute on Deafness and Other Communication Disorders (NIDCD), National Institutes of Health (NIH), Bethesda, MD
09/02-07/07 Consultant in Psychology, McLean Hospital, Belmont, MA
08/07- Research Psychologist, McLean Hospital, Belmont, MA

**Other Professional Positions**

11/01-08/02 First Lieutenant, Medical Service Corps, United States Army Reserve (USAR)
08/02-07/05 Captain, Medical Service Corps, United States Army
08/05-10/07 Major, Medical Service Corps, United States Army
10/07-10/12 Major, Medical Service Corps, United States Army Reserve (USAR)
08/08- Consulting Psychologist, The Brain Institute, University of Utah
07/12- Lieutenant Colonel, Medical Service Corps, United States Army Reserve (USAR)

**Major Administrative Leadership Positions**

**Local**

1988-1989 Undergraduate Teaching Assistant-Introduction to Psychology 102, University of New Mexico
1990-1991 Graduate Teaching Assistant-General Psychology 1300, Texas Tech University
1991-1992 Graduate Teaching Assistant-Psychology of Learning Laboratory 3317, Texas Tech University
2004-2007 Chief, Neurocognitive Performance Branch, Walter Reed Army Institute of Research, Silver Spring, MD
2005-2006 Neuropsychology Postdoctoral Program Training Supervisor, Walter Reed Hospital, Washington, DC
2011- Co-Director, Social, Cognitive, and Affective Neuroscience Laboratory, McLean Hospital, Belmont, MA
**Committee Service**

**Local**

2003  
Scientific Review Committee, Walter Reed Army Institute of Research (WRAIR), Silver Spring, MD

2005  
Scientific Review Committee, Walter Reed Army Institute of Research (WRAIR), Silver Spring, MD

2012-  
McLean Hospital Research Committee, McLean Hospital, Belmont, MA

**Regional**

2005-2006  
Undergraduate Honors Thesis Committee, Jessica Richards [Chairperson], University of Maryland, Baltimore County

2011  
Scientific Review Committee, U.S. Army Institute of Environmental Medicine (USARIEM), Natick, MA

**National**

2011-  
National Network of Depression Centers, Military Task Group

**International**

2005-2006  
Doctoral Thesis Committee, Belinda J. Liddell, University of Sydney, Australia

**Professional Societies**

1995-1997  
American Psychological Association, Member

1998-2000  
National Academy of Neuropsychology, Member

2012-  
American Academy of Sleep Medicine, Member

2014-  
Organization for Human Brain Mapping, Member

**Grant Review Activities**

**National**

2004  
University of Alabama, Clinical Nutrition Research Center (UAB CNRC) Pilot/Feasibility Study Program Review Committee

2006  
U.S. Small Business Administration, Small Business Technology Transfer (STTR) Program Review Committee

2006  
Cognitive Performance Assessment Program Area Steering Committee, U.S. Army Military Operational Medicine Research Program Funding Panel

2007  
Cognitive Performance Assessment Program Area Steering Committee, U.S. Army Military Operational Medicine Research Program Funding Panel

2008  
United States Army Medical Research and Materiel Command (USAMRMC) Congressionally Directed Medical Research Programs (CDMRP) Extramural Grant Review Panel

2009  
NIH-CSIR Brain Disorders and Clinical Neuroscience N02 Member Study Conflict Section Review Panel

2009  
Sleep Physiology and Fatigue Interventions Program Area Steering Committee, U.S. Army Military Operational Medicine Research Program

2011  
National Science Foundation (NSF) Grant Reviewer

2012  
National Science Foundation (NSF) Grant Reviewer
### International

- **2009** Scotland, UK, Biomedical and Therapeutic Research Committee, Grant Reviewer
- **2010** Canada, Social Sciences and Humanities Research Council of Canada, Grant Reviewer
- **2011** Israel, Israel Science Foundation (ISF), Grant Reviewer
- **2013** Israel, Israel Science Foundation (ISF), Grant Reviewer

### Editorial Activities

<table>
<thead>
<tr>
<th>Year</th>
<th>Journal/Conference</th>
<th>Role</th>
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<tbody>
<tr>
<td>2001-2012</td>
<td>Reviewer, Psychological Reports</td>
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<tr>
<td>2001-2012</td>
<td>Reviewer, Perceptual and Motor Skills</td>
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<tr>
<td>2002</td>
<td>Reviewer, American Journal of Psychiatry</td>
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<tr>
<td>2002-2013</td>
<td>Reviewer, Biological Psychiatry</td>
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<tr>
<td>2003</td>
<td>Reviewer, Clinical Neurology and Neurosurgery</td>
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<tr>
<td>2004, 2013</td>
<td>Reviewer, NeuroImage</td>
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<tr>
<td>2004-2006</td>
<td>Reviewer, Neuropsychologia</td>
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<tr>
<td>2004</td>
<td>Reviewer, Journal of Neuroscience</td>
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<tr>
<td>2004</td>
<td>Reviewer, Consciousness and Cognition</td>
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<tr>
<td>2005</td>
<td>Reviewer, Experimental Brain Research</td>
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<tr>
<td>2005</td>
<td>Reviewer, Schizophrenia Research</td>
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<tr>
<td>2005-2012</td>
<td>Reviewer, Archives of General Psychiatry</td>
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<tr>
<td>2005</td>
<td>Reviewer, Behavioral Brain Research</td>
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<td>2005-2009</td>
<td>Reviewer, Human Brain Mapping</td>
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<tr>
<td>2005-2013</td>
<td>Reviewer, Psychiatry Research: Neuroimaging</td>
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<td>2006</td>
<td>Reviewer, Journal of Abnormal Psychology</td>
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<td>2006</td>
<td>Reviewer, Psychopharmacology</td>
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<td>2006</td>
<td>Reviewer, Developmental Science</td>
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<td>2006</td>
<td>Reviewer, Acta Psychologica</td>
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<td>2006</td>
<td>Reviewer, Neuroscience Letters</td>
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<tr>
<td>2006-2014</td>
<td>Reviewer, Journal of Sleep Research</td>
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<tr>
<td>2006-2013</td>
<td>Reviewer, Physiology and Behavior</td>
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<tr>
<td>2006-2014</td>
<td>Reviewer, SLEEP</td>
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<tr>
<td>2007</td>
<td>Reviewer, Journal of Clinical and Experimental Neuropsychology</td>
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<tr>
<td>2008</td>
<td>Reviewer, European Journal of Child and Adolescent Psychiatry</td>
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<td>2008</td>
<td>Reviewer, Judgment and Decision Making</td>
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<tr>
<td>2008-2010</td>
<td>Reviewer, Aviation, Space, &amp; Environmental Medicine</td>
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<td>2008</td>
<td>Reviewer, Journal of Psychophysiology</td>
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<td>2008</td>
<td>Reviewer, Brazilian Journal of Medical and Biological Research</td>
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<td>2008</td>
<td>Reviewer, The Harvard Undergraduate Research Journal</td>
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<td>2008</td>
<td>Reviewer, Bipolar Disorders</td>
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<td>2008-2013</td>
<td>Reviewer, Chronobiology International</td>
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<td>2008</td>
<td>Reviewer, International Journal of Obesity</td>
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<td>2009</td>
<td>Reviewer, European Journal of Neuroscience</td>
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<td>2009</td>
<td>Reviewer, Psychophysiology</td>
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<td>2009</td>
<td>Reviewer, Traumatology</td>
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<td>2009</td>
<td>Reviewer, Clinical Medicine: Therapeutics</td>
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<tr>
<td>2009</td>
<td>Reviewer, Acta Pharmacologica Sinica</td>
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<tr>
<td>2009</td>
<td>Reviewer, Collegium Antropologicum</td>
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</tbody>
</table>
2009  Reviewer, Journal of Psychopharmacology
2009-2014 Reviewer, Obesity
2009  Reviewer, Scientific Research and Essays
2009  Reviewer, Child Development Perspectives
2009-2010 Reviewer, Personality and Individual Differences
2009-2010 Reviewer, Noise and Health
2009-2010 Reviewer, Sleep Medicine
2010  Reviewer, Nature and Science of Sleep
2010  Reviewer, Psychiatry and Clinical Neurosciences
2010  Reviewer, Learning and Individual Differences
2010  Reviewer, Cognitive, Affective, and Behavioral Neuroscience
2010  Reviewer, BMC Medical Research Methodology
2010-2011 Reviewer, Journal of Adolescence
2010-2012 Reviewer, Brain Research
2011  Reviewer, Brain
2011  Reviewer, Social Cognitive and Affective Neuroscience
2011  Reviewer, Journal of Traumatic Stress
2011  Reviewer, Social Neuroscience
2011-2014 Reviewer, Brain and Cognition
2011  Reviewer, Frontiers in Neuroscience
2011-2012 Reviewer, Sleep Medicine Reviews
2012  Reviewer, Journal of Experimental Psychology: General
2012  Reviewer, Ergonomics
2012  Reviewer, Behavioral Sleep Medicine
2012  Reviewer, Neuropsychology
2012  Reviewer, Emotion
2012  Reviewer, JAMA
2012  Reviewer, BMC Neuroscience
2012  Reviewer, Cognition and Emotion
2012  Reviewer, Journal of Behavioral Decision Making
2012  Reviewer, Psychosomatic Medicine
2012-2014 Reviewer, PLoS One
2012  Reviewer, American Journal of Critical Care
2012-2014 Reviewer, Journal of Sleep Disorders: Treatment and Care
2013  Reviewer, Experimental Psychology
2013  Reviewer, Clinical Interventions in Aging
2013  Reviewer, Frontiers in Psychology
2013  Reviewer, Brain Structure and Function
2013  Reviewer, Appetite
2013  Reviewer, JAMA Psychiatry
2014  Reviewer, Acta Psychologica
2014  Reviewer, Neurology
2014  Reviewer, Applied Neuropsychology: Child

Other Editorial Roles
2009- Editorial Board Member  International Journal of Eating Disorders
2012- Editor  Datasets in Neuroscience
2012- Editor Datasets in Medicine
2012- Editor Journal of Sleep Disorders: Treatment and Care

**Honors and Prizes**

1990 Outstanding Senior Honors Thesis in Psychology, University of New Mexico
1990-1995 Maxey Scholarship in Psychology, Texas Tech University
2001 Rennick Research Award, Co-Author, International Neuropsychological Society
2002 Honor Graduate, AMEDD Officer Basic Course, U.S. Army Medical Department Center and School
2002 Lynch Leadership Award Nominee, AMEDD Officer Basic Course, U.S. Army Medical Department Center and School
2003 Outstanding Research Presentation Award, 2003 Force Health Protection Conference, U.S. Army Center for Health Promotion and Preventive Medicine
2005 Edward L. Buescher Award for Excellence in Research by a Young Scientist, Walter Reed Army Institute of Research (WRAIR) Association
2009 Merit Poster Award, International Neuropsychological Society
2009 Outstanding Research Presentation Award, 2009 Force Health Protection Conference, U.S. Army Center for Health Promotion and Preventive Medicine
2010 Best Paper Award, Neuroscience, 27th U.S. Army Science Conference
2011 Published paper included in *Best of Sleep Medicine 2011*
2011 Blue Ribbon Finalist, 2011 Top Poster Award in Clinical and Translational Research, Society of Biological Psychiatry
2012 Defense Advance Research Projects Agency (DARPA) Young Faculty Award in Neuroscience
2014 Blue Ribbon Finalist, 2014 Top Poster Award in Basic Neuroscience, Society of Biological Psychiatry
2014 Harvard Medical School Excellence in Mentoring Award Nominee
2014 AASM Young Investigator Award, Honorable Mention, Co-Author, American Academy of Sleep Medicine

**Report of Funded and Unfunded Projects**

**Funding Information**

**Past**

N.I.H., 1R03HD41542-01
P.I.: Killgore ($79,000.)

U.S. Army Medical Research and Materiel Command (USAMRMC) Competitive Medical Research Proposal Program (CMRP),
P.I.: Killgore (Total Award: $1,345,000.)
2004-2005  Sleep/wake Schedules in 3ID Aviation Brigade Soldiers.
Defense Advanced Research Projects Agency (DARPA)
P.I.: Killgore (Total Award: $60,000.)

2005-2006  Functional Neuroimaging Studies of Neural Processing Changes with Sleep and Sleep Deprivation.
U.S. Army Medical Research and Materiel Command (USAMRMC)
Task Area C (Warfighter Judgment and Decision Making) Program Funding
P.I.: Killgore (Total Award: $219,400.)

2006-2007  Establishing Normative Data Sets for a Series of Tasks to Measure the Cognitive Effects of Operationally Relevant Stressors.
U.S. Army Medical Research and Materiel Command (USAMRMC)
Task Area C (Warfighter Judgment and Decision Making) Program Funding,
P.I.: Killgore  (Total Award: $154,000.)

2006-2007  Military Operational Medicine Research Program (MOM-RP), Development of the Sleep History and Readiness Predictor (SHARP).
U.S. Army Medical Research and Materiel Command (USAMRMC)
P.I.: Killgore (Total Award:$291,000.)

Current  
U.S. Army Medical Research and Materiel Command (USAMRMC),
P.I.: Killgore (Total Award: $551,961.)
Major Goal: To identify the neurobiological basis of cognitive and emotional intelligence using functional and structural magnetic resonance imaging.

2011-2014  Effects of Bright Light Therapy on Sleep, Cognition, and Brain Function following Mild Traumatic Brain Injury.
U.S. Army Medical Research and Materiel Command (USAMRMC),
P.I.: Killgore  (Total Award: $941,924)
Major Goal: To evaluate the effectiveness of morning exposure to bright light as a treatment for improving in sleep patterns among individuals with post-concussive syndrome. Effects of improved sleep on recovery due to this treatment will be evaluated using neurocognitive testing as well as functional and structural neuroimaging.

2012-2015  Internet Based Cognitive Behavioral Therapy Effects on Depressive Cognitions and Brain function.
U.S. Army Medical Research and Materiel Command (USAMRMC),
Co-PI: Killgore (Total Award: $1,646,045)
Major Goal: To evaluate the effectiveness of an internet-based cognitive behavioral therapy treatment program on improving depressive symptoms, coping and resilience skills, cognitive processing and functional brain activation patterns within the prefrontal cortex.
2012-2014  Multimodal Neuroimaging to Predict Cognitive Resilience Against Sleep Loss
Defense Advance Research Projects Agency (DARPA) Young Faculty Award in Neuroscience
P.I.: Killgore (Total Award: $445,531)
Major Goal: To combine several neuroimaging techniques, including functional and structural magnetic resonance imaging, diffusion tensor imaging, and magnetic resonance spectroscopy to predict individual resilience to 24 hours of sleep deprivation.

2012-2016  A Model for Predicting Cognitive and Emotional Health from Structural and Functional Neurocircuitry following Traumatic Brain Injury
Congressionally Directed Medical Research Program (CDMRP), Psychological Health/Traumatic Brain Injury (PH/TBI) Research Program: Applied Neurotrauma Research Award.
P.I.: Killgore (Total Award: $2,272,098)
Major Goal: To evaluate the relation between axonal damage and neurocognitive performance in patients with traumatic brain injury at multiple points over the recovery trajectory, in order to predict recovery.

2012-2014  Neural Mechanisms of Fear Extinction Across Anxiety Disorders
NIH NIMH
Site Subcontract PI: Killgore (Subcontract Award: $505,065)
Major Goal: To examine the neurocircuitry involved in fear conditioning, extinction, and extinction recall across several major anxiety disorders.

2014-2017  Bright Light Therapy for Treatment of Sleep Problems following Mild TBI.
Psychological Health and Traumatic Brain Injury Research Program (PH/TBI RP) Traumatic Brain Injury Research Award-Clinical Trial.
P.I.: Killgore (Total Award: $1,853,921)
Major Goal: To verify the effectiveness of morning exposure to bright light as a treatment for improving in sleep patterns, neurocognitive performance, brain function, and brain structure among individuals with a recent mild traumatic brain injury.

2014-2018  A Non-pharmacologic Method for Enhancing Sleep in PTSD
P.I.: Killgore (Total Award: $3,821,415)
Major Goal: To evaluate the effectiveness of blue light exposure to modify sleep in PTSD and its effects on fear conditioning/extinction, symptom expression, and brain functioning.

Report of Local Teaching and Training

Laboratory and Other Research Supervisory and Training Responsibilities

2005-2006  1 Fellow for 250 hrs/year, Neuropsychology Postdoctoral Research Training Program Supervisor, Walter Reed Hospital

2011-     2 Fellows for 2080 hrs/year, Harvard Research Fellow Supervisor, McLean Hospital
Formally Supervised Trainees

1997-1999  David Glahn, Ph.D.  Associate Professor, Yale University School of Medicine
Provided mentorship in clinical neuropsychological assessment and research at the University of Pennsylvania Hospital, which resulted in the development of a new psychometric test, 1 co-authored published conference abstract, and 1 co-authored published journal article.

1997-1999  Daniel Casasanto, Ph.D.  Assistant Professor, University of Chicago
Supervised this trainee while at the University of Pennsylvania Hospital, which resulted in the development of a new psychometric test, 9 co-authored published conference abstracts, and 5 co-authored published journal articles.

2002-2005  Alexander Vo, Ph.D.  Associate Professor, UTMB; Vice President, Electronically Mediated Services, Colorado Access
Served as one of his research mentors at the Walter Reed Army Institute of Research, which resulted in 3 co-authored published conference abstracts, and 3 co-authored published journal articles.

2002-2007  Rebecca Reichardt, M.A.  Human Subjects Protection Scientist, USAMRMC
Supervised her research training in my lab at the Walter Reed Army Institute of Research, which resulted in 10 co-authored published conference abstracts, and 2 co-authored published journal articles.

2003-2004  Stan Liu, M.D.  Medical Intern, Johns Hopkins Medical School
Supervised his research training in my lab at the Walter Reed Army Institute of Research, which primarily involved training in neuropsychological assessment and sleep research methods.

2003-2004  Neil Arora, B.A.  Student, Yale University
Supervised his research project in my lab at the Walter Reed Army Institute of Research and NIH, which primarily involved training in brain imaging analysis and led to 2 co-authored published conference abstracts.

2003-2005  Nancy Grugle, Ph.D.  Assistant Professor, Cleveland State University
Supervised her Doctoral Dissertation research project in my lab at the Walter Reed Army Institute of Research, which resulted in 23 co-authored published conference abstracts, and 10 co-authored published journal articles.

2003-2005  Joshua Bailey, B.A.  Seminary Student
Supervised his computer programming development and research in my lab at the Walter Reed Army Institute of Research, which resulted in 1 co-authored published conference abstract, and 1 co-authored computer analysis package submitted for U.S. patent.

2003-2006  Athena Kendall, M.A.  Lab Manager, Walter Reed Army Medical Center
Supervised part of her masters degree research project and other research work in my lab at the Walter Reed Army Institute of Research, which resulted in 4 co-authored published conference abstracts, and 4 co-authored published journal articles.

Supervised her research training and work in my lab at the Walter Reed Army Institute of Research, which resulted in 3 co-authored published conference abstracts, and 1 co-authored published journal article.

2004-2005  Merica Shepherd, B.A.  Laboratory Coordinator
Supervised her research training in my lab at the Walter Reed Army Institute of Research, which primarily involved training in neuropsychological assessment and sleep research methods.
2004-2005  Cynthia Hawes, B.A.  Research Program Coordinator
Supervised her research training in my lab at the Walter Reed Army Institute of Research, which primarily involved training in neuropsychological assessment and sleep research methods.

2004-2006  Christopher Li, B.A.  Graduate Student
Supervised his research training and work in my lab at the Walter Reed Army Institute of Research, which resulted in 3 co-authored published conference abstracts, and 1 co-authored published journal article.

2004-2007  Jessica Richards, M.S.  Ph.D. Student, University of Maryland College Park
Served as Chair of her Senior Honors Thesis Committee and supervised her research work in my lab at the Walter Reed Army Institute of Research, which resulted in 8 co-authored published conference abstracts, a senior honors thesis, and 2 co-authored published journal articles.

2004-2007  Erica Lipizzi, M.A.  Graduate Student, Emory University
Supervised her research training and work in my lab at the Walter Reed Army Institute of Research, which resulted in 16 co-authored published conference abstracts, and 12 co-authored published journal articles.

2004-2007  Brian Leavitt, B.S.  Research Technician, Walter Reed Army Institute of Research
Supervised his research training and work in my lab at the Walter Reed Army Institute of Research, which resulted in 4 co-authored published conference abstracts, and 1 co-authored published journal article.

2004-2007  Rachel Newman, M.S.  Senior Laboratory Manager, Walter Reed
Supervised her research training and work in my lab at the Walter Reed Army Institute of Research, which resulted in 6 co-authored published conference abstracts, and 1 co-authored published journal article.

2004-2007  Alexandra Krugler, B.S.  Medical Student, Louisiana State University
Supervised her research training and work in my lab at the Walter Reed Army Institute of Research, which resulted in 5 co-authored published conference abstracts, and 1 co-authored published journal article.

Supervised her research training and work in my lab at the Walter Reed Army Institute of Research, which resulted in 4 co-authored published conference abstracts, and 1 co-authored published journal article.

2005-2006  Nathan Huck, PH.D.  Clinical Neuropsychologist, Walter Reed Army Institute of Research
Served as his post-doctoral research training supervisor at the Walter Reed Army Institute of Research, which resulted in 1 co-authored published conference abstract and 1 co-authored published journal article.

2005-2006  Ellen Kahn-Greene, Ph.D.  Post-Doctoral Fellow, Boston VA
Supervised her research training and work in my lab at the Walter Reed Army Institute of Research, which resulted in 7 co-authored published conference abstracts and 5 co-authored published journal articles.

2005-2006  Alison Muckle, B.A.  Research Technician
Supervised her research training and work in my lab at the Walter Reed Army Institute of Research, which resulted in 1 co-authored published conference abstract and 1 co-authored published journal article.
2005-2006  Christina Murray, B.S.  Medical Student, Drexel University
Supervised her research training and work in my lab at the Walter Reed Army Institute of Research, which resulted in 2 co-authored published conference abstracts.

2005-2007  Gautham Ganesan, M.D.  Medical Student, UC Irvine
Supervised his research training and work in my lab at the Walter Reed Army Institute of Research, which resulted in 1 co-authored published conference abstract and 1 co-authored published journal article.

2005-2007  Dante Picchioni, Ph.D.  Research Psychologist, Walter Reed Army Institute of Research
Supervised part of his post-doctoral brain imaging research training at the Walter Reed Army Institute of Research, which resulted in 1 co-authored published conference abstract and 1 co-authored published journal article.

2005-2007  Tracy Rupp, Ph.D.  Research Psychologist, Walter Reed Army Institute of Research
Supervised part of her post-doctoral sleep research training at the Walter Reed Army Institute of Research, which resulted in 17 co-authored conference abstracts and 2 co-authored published journal articles.

2006-2007  Kacie Smith, B.A.  Study Manager, Walter Reed Army Institute of Research
Supervised her research training and work in my lab at the Walter Reed Army Institute of Research, which resulted in 7 co-authored published conference abstracts.

2006-2007  Shane Smith, B.S.  Medical Student, University of the West Indies
Served as his research mentor at the Walter Reed Army Institute of Research, which primarily involved training in neuropsychological assessment and sleep research methods.

2006-2007  Shanelle McNair  Research Technician, Walter Reed Army Institute of Research
Supervised her research training and work in my lab at the Walter Reed Army Institute of Research, which resulted in 1 co-authored published article.

2006-2007  George Watlington  Research Technician, Walter Reed Army Institute of Research
Supervised his research training and work in my lab at the Walter Reed Army Institute of Research, which resulted in 1 co-authored published article.

2008  Grady O’Brien  Undergraduate Student
Served as his summer volunteer research mentor at McLean Hospital, which resulted in 1 oral research presentation

2008-2009  Alex Post  Undergraduate Student, Carnegie Mellon University
Served as his summer volunteer research mentor at McLean Hospital, which resulted in 2 oral research presentations and 1 co-authored published abstract.

2008-2009  Lauren Price, B.A.  Senior Clinical Research Assistant, McLean Hospital
Supervised her research training and work in my lab at the McLean Hospital, which resulted in 11 co-authored published conference abstracts and 4 co-authored published articles.

2009-2013  Zachary Schwab, B.S.  Medical Student, University of Kansas
Supervised his research training and work in my lab at the McLean Hospital, which resulted in 79 co-authored published conference abstracts and 15 co-authored published articles.
<table>
<thead>
<tr>
<th>Year</th>
<th>Name</th>
<th>Position</th>
<th>Institution</th>
<th>Description</th>
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<tbody>
<tr>
<td>2009-2011</td>
<td>Melissa Weiner, B.S.</td>
<td>Graduate Student</td>
<td>Yale School of Public Health</td>
<td>Supervised her research training and work in my lab at the McLean Hospital, which resulted in 35 co-authored published conference abstracts and 7 co-authored published articles.</td>
</tr>
<tr>
<td>2010-2011</td>
<td>Norah Simpson, Ph.D.</td>
<td>Post-Doctoral Fellow</td>
<td>Beth Israel Deaconess/Harvard Medical School</td>
<td>Served as a research mentor on her federal K-Award grant application.</td>
</tr>
<tr>
<td>2010-2012</td>
<td>Vincent Capaldi, M.D.</td>
<td>Medical Resident</td>
<td>Walter Reed Army Medical Ctr.</td>
<td>Served as his post-doctoral research mentor, which resulted in 1 co-authored published conference abstract and 2 co-authored published articles.</td>
</tr>
<tr>
<td>2010-2011</td>
<td>Christina Song</td>
<td>Undergraduate Student</td>
<td>Smith College</td>
<td>Served as her summer volunteer research mentor at McLean Hospital, which resulted in 1 co-authored published abstract.</td>
</tr>
<tr>
<td>2011</td>
<td>Jill Kizielewicz</td>
<td>Undergraduate Student</td>
<td>Hamilton College</td>
<td>Served as her summer volunteer research mentor at McLean Hospital, which resulted in 1 co-authored published abstract.</td>
</tr>
<tr>
<td>2011-2013</td>
<td>Sophie DelDonno, B.A.</td>
<td>Doctoral Student</td>
<td>University of Illinois, Chicago</td>
<td>Supervised her research training and work in my lab at the McLean Hospital, which resulted in 34 co-authored published conference abstracts and 9 co-authored published articles.</td>
</tr>
<tr>
<td>2011-</td>
<td>Maia Kipman, B.A.</td>
<td>Research Assistant</td>
<td>McLean Hospital</td>
<td>Supervised her research training and work in my lab at the McLean Hospital, which resulted in 42 co-authored published conference abstracts and 10 co-authored published articles.</td>
</tr>
<tr>
<td>2011</td>
<td>Michael Covell, B.A.</td>
<td>Graduate Student</td>
<td>Baruch College</td>
<td>Served as one of his research mentors at McLean Hospital, which resulted in 4 co-authored published conference abstracts, and 1 co-authored published article.</td>
</tr>
<tr>
<td>2011-</td>
<td>Mareen Weber, Ph.D.</td>
<td>Instructor</td>
<td>Harvard Medical School</td>
<td>Supervised her post-doctoral research training and work in my lab at the McLean Hospital, which has resulted in 49 co-authored published conference abstracts, 15 co-authored published articles, 1 co-authored book chapter, 1 travel award, five federal grant submissions, and 2 successfully funded grants.</td>
</tr>
<tr>
<td>2012-</td>
<td>Julia Cohen, Ph.D.</td>
<td>Post-Doctoral Fellow</td>
<td>Harvard Medical School</td>
<td>Served as one of her research mentors at McLean Hospital, which resulted in 6 co-authored published conference abstracts and 1 peer-reviewed publication.</td>
</tr>
<tr>
<td>2012-</td>
<td>Christian Webb, Ph.D.</td>
<td>Post-Doctoral Fellow</td>
<td>Harvard Medical School</td>
<td>Currently supervising his post-doctoral research training and work in my lab at the McLean Hospital, which has resulted in 9 co-authored published conference abstracts and 6 peer-reviewed publications.</td>
</tr>
<tr>
<td>2012-</td>
<td>Hannah Gogel, B.S.</td>
<td>Research Assistant</td>
<td>McLean Hospital</td>
<td>Supervised her research training and work in my lab at the McLean Hospital, which resulted in 21 co-authored published conference abstracts and 4 co-authored published articles.</td>
</tr>
<tr>
<td>2012-</td>
<td>Olga Tkachenko, A.B.</td>
<td>Research Assistant</td>
<td>McLean Hospital</td>
<td>Supervised her research training and work in my lab at the McLean Hospital, which resulted in 23 co-authored published conference abstracts and 4 co-authored published articles.</td>
</tr>
</tbody>
</table>
Lilly Preer, B.A.  
Supervised her research training and work in my lab at the McLean Hospital, which resulted in 22 co-authored published conference abstracts and 3 co-authored published articles.

Elizabeth Mundy, Ph.D  
Supervised her post-doctoral research training and work in my lab at the McLean Hospital, which resulted in 3 co-authored published conference abstracts and 2 co-authored published articles.

John S. Bark, B.A.  
Supervised his research training and work in my lab at the McLean Hospital, which resulted in 5 co-authored published conference abstracts, and 2 co-authored published articles.

Shreya Divatia, B.S.  
Supervised her research training and work in my lab at the McLean Hospital, which resulted in 9 co-authored published conference abstracts.

Lauren Demers, B.A.  
Supervised her research training and work in my lab at the McLean Hospital, which resulted in 10 co-authored published conference abstracts.

Jiaolong Cui, Ph.D  
Supervised his post-doctoral research training and work in my lab at the McLean Hospital, which resulted in 9 co-authored published conference abstracts.

Allison Jorgensen  
Supervised her research training and work in my lab at the McLean Hospital.

Leslie Amrein  
Supervised her research training and work in my lab at the McLean Hospital.

Alexa Curhan  
Supervised her research training and work in my lab at the McLean Hospital.

Kate Manganello  
Supervised her research training and work in my lab at the McLean Hospital.

Mia Kaminsky  
Supervised her research training and work in my lab at the McLean Hospital.

Jennifer Buchholz  
Supervised her research training and work in my lab at the McLean Hospital.

Joseph Dagher, Ph.D.  
Mentored his K-Award and CECS grant applications.

Ryan Smith, B.S.  
Mentored his F32- grant application.

John Vanuk, B.A.  
Supervised his research training in my lab.

Sarah Markowski  
Supervised her research training in my lab.

Derek Pisner, B.S.  
Supervised his research training in my lab.

Bradley Shane, B.S.  
Supervised his research training in my lab.

Andrew Fridman, B.A.  
Supervised his research training in my lab.
2014 Anna Alkozei, Ph.D. Postdoctoral Fellow, University of Arizona

*Supervised her post-doctoral research training and work in my lab.*

**Local Invited Presentations**

2000 The Neurobiology of Emotion in Children, McLean Hospital
Lecturer: 30 participants, 2 hours contact time per year, 10 hours prep time per year.
[Invited Lecture]

2001 The Neurobiology of Emotion in Children and Adolescents, McLean Hospital
Lecturer: 60 participants, 2 hours contact time per year, 10 hours prep time per year.
[Invited Lecture]

2001 Using Functional MRI to Study the Developing Brain, Judge Baker Children's Center
Lecturer: 8 participants, 2 hours contact time per year, 10 hours prep time per year [Invited Seminar]

2005 Briefing to the Chairman of the Congressional Committee on Strategies to Protect the Health of Deployed U.S. Forces, John H. Moxley, on the Optimization of Judgment and Decision Making Capacities in Soldiers Following Sleep Deprivation, Walter Reed Army Institute of Research, Washington, DC [Invited Lecture]


2006 Lecture on Optimization of Judgment and Decision Making Capacities in Soldiers Following Sleep Deprivation, Brain Imaging Center, McLean Hospital, Belmont MA [Invited Lecture]


2010 Lecture on Patterns of Cortico-Limbic Activation Across Anxiety Disorders, Center for Anxiety, Depression, and Stress, McLean Hospital, Belmont, MA [Invited Lecture]

2010 Lecture on Cortico-Limbic Activation Among Anxiety Disorders, Neuroimaging Center, McLean Hospital, Belmont, MA [Invited Lecture]

2011 Lecture on Shared and Differential Patterns of Cortico-Limbic Activation Across Anxiety Disorders, McLean Research Day Brief Communications, McLean Hospital, Belmont, MA [Invited Lecture]

2012 Briefing to GEN (Ret) George Casey Jr., former Chief of Staff of the U.S. Army, entitled Research for the Soldier. McLean Hospital, Belmont, MA [Invited Lecture]
2014  Lecture entitled Sleep Loss, Brain Function, and Cognitive Performance, presented to the Psychiatric Genetics and Translational Research Seminar, Massachusetts General Hospital/Harvard Medical School, Boston, MA. [Invited Lecture]

Report of Regional, National and International Invited Teaching and Presentations

Invited Presentations and Courses

Regional

2002  Cortico-Limbic Activation in Adolescence and Adulthood, Youth Advocacy Project, Cape Cod, MA
Lecturer: 45 participants, 2 hours contact time per year, 10 hours prep time per year
[Invited Lecture]


2007  Lecture on Cerebral Responses During Visual Processing of Food, U.S. Army Institute of Environmental Medicine, Natick, MA [Invited Lecture]


2008  Lecture on Sleep Deprivation, Executive Function, and Resilience to Sleep Loss; 105th IMA Detachment, U.S. Army Reserve Center, Boston, MA [Invited Lecture]

2008  Lecture on the Role of Research Psychology in the Army; 105th IMA Detachment, U.S. Army Reserve Center, Boston, MA [Invited Lecture]

2008  Lecture on Combat Stress Control: Basic Battlemind Training; 105th IMA Detachment, U.S. Army Reserve Center, Boston, MA [Invited Lecture]

2009  Lecture entitled Evaluate a Casualty, Prevent Shock, and Prevent Cold Weather injuries; 105th IMA Detachment, U.S. Army Reserve Center, Boston, MA [Invited Lecture]

2009  Lecture on Combat Exposure and Sleep Deprivation Effects on Risky Decision-Making; 105th IMA Detachment, U.S. Army Reserve Center, Boston, MA [Invited Lecture]

2009  Lecture on the Sleep History and Readiness Predictor (SHARP); 105th IMA Detachment, U.S. Army Reserve Center, Boston, MA [Invited Lecture]
2009  Lecture on The Use of Actigraphy for Measuring Sleep in Combat and Military Training; 105th IMA Detachment, U.S. Army Reserve Center, Boston, MA [Invited Lecture]

2010  Lecture entitled Casualty Evaluation; 105th IMA Detachment, U.S. Army Reserve Center, Boston, MA [Invited Lecture]

2010  Lecture entitled Combat Stress and Risk-Taking Behavior Following Deployment; 105th IMA Detachment, U.S. Army Reserve Center, Boston, MA [Invited Lecture]

2010  Lecture entitled Historical Perspectives on Combat Medicine at the Battle of Gettysburg; 105th IMA Detachment, U.S. Army Reserve Center, Boston, MA [Invited Lecture]

2010  Lecture entitled Sleep Loss, Stimulants, and Decision-Making; 105th IMA Detachment, U.S. Army Reserve Center, Boston, MA [Invited Lecture]

2010  Lecture entitled PTSD: New Insights from Brain Imaging; 105th IMA Detachment, U.S. Army Reserve Center, Boston, MA [Invited Lecture]

2011  Lecture entitled Effects of bright light therapy on sleep, cognition and brain function after mild traumatic brain injury; 105th IMA Detachment, U.S. Army Reserve Center, Boston, MA [Invited Lecture]

2011  Lecture entitled Laboratory Sciences and Research Psychology in the Army; 105th IMA Detachment, U.S. Army Reserve Center, Boston, MA [Invited Lecture]

2011  Lecture entitled Tools for Assessing Sleep in Military Settings; 105th IMA Detachment, U.S. Army Reserve Center, Boston, MA [Invited Lecture]

2011  Lecture entitled The Brain Basis of Emotional Trauma and Practical Issues in Supporting Victims of Trauma, U.S. Department of Justice, United States Attorneys Office, Serving Victims of Crime Training Program, Holyoke, MA [Invited Lecture]

2011  Lecture entitled The Brain Altering Effects of Traumatic Experiences; 105th Reinforcement Training Unit (RTU), U.S. Army Reserve Center, Boston, MA [Invited Lecture]

2012  Lecture entitled Sleep Loss, Caffeine, and Military Performance; 105th IMA Detachment, U.S. Army Reserve Center, Boston, MA [Invited Lecture]

2012  Lecture entitled Using Light Therapy to Treat Sleep Disturbance Following Concussion; 105th IMA Detachment, U.S. Army Reserve Center, Boston, MA [Invited Lecture]

2013  Lecture entitled Brain Responses to Food: What you See Could Make you Fat; 105th IMA Detachment, U.S. Army Reserve Center, Boston, MA [Invited Lecture]
2013 Lecture entitled Predicting Resilience Against Sleep Loss; 105th IMA Detachment, U.S. Army Reserve Center, Boston, MA [Invited Lecture]

2014 Lecture entitled Get Some Shut-Eye or Get Fat: Sleep Loss Affects Brain Responses to Food; 105th IMA Detachment, U.S. Army Reserve Center, Boston, MA [Invited Lecture]

National 2000 Lecture on the Neurobiology of Emotional Development in Children, 9th Annual Parents as Teachers Born to Learn Conference, St. Louis, MO [Invited Lecture]


2005 Lecture on The Sleep History and Readiness Predictor: Presented to the Medical Research and Materiel Command, Ft. Detrick, MD [Invited Lecture]

2006 Lecture on The Sleep History and Readiness Predictor: Presented at the Bi-Annual 71F Research Psychology Short Course, Ft. Rucker, AL, U.S. Army Medical Research and Materiel Command [Invited Lecture]


2008 Lecture on the Validation of Actigraphy and the SHARP as Methods of Measuring Sleep and Performance in Soldiers, U.S. Army Aeromedical Research Laboratory, Fort Rucker, AL [Seminar]

2009 Lecture on Sleep Deprivation, Executive Function, and Resilience to Sleep Loss: Walter Reed Army Institute of Research AIBS Review, Washington DC [Invited Lecture]
2009 Lecture Entitled: Influences of Combat Exposure and Sleep Deprivation on Risky Decision-Making, Evans U.S. Army Hospital, Fort Carson, CO [Invited Lecture]

2009 Lecture on Making Bad Choices: The Effects of Combat Exposure and Sleep Deprivation on Risky Decision-Making, 4th Army, Division West, Quarterly Safety Briefing to the Commanding General and Staff, Fort Carson, CO [Invited Lecture]

2009 Symposium Entitled: Sleep Deprivation, Judgment, and Decision-Making, 23rd Annual Meeting of the Associated Professional Sleep Societies, Seattle, WA [Invited Symposium]

2009 Symposium Session Moderator: Workshop on Components of Cognition and Fatigue: From Laboratory Experiments to Mathematical Modeling and Operational Applications, Washington State University, Spokane, WA [Invited Speaker]

2009 Lecture on Comparative Studies of Stimulant Action as Countermeasures for Higher Order Cognition and Executive Function Impairment that Results from Disrupted Sleep Patterns, Presented at the NIDA-ODS Symposium entitled: Caffeine: Is the Next Problem Already Brewing, Rockville, MD [Invited Lecture]

2010 Oral Platform Presentation: Sleep deprivation selectively impairs emotional aspects of cognitive functioning, 27th Army Science Conference, Orlando, FL.

2010 Oral Platform Presentation: Exaggerated amygdala responses to masked fearful faces are specific to PTSD versus simple phobia, 27th Army Science Conference, Orlando, FL.

2011 Lecture Entitled: The effects of emotional intelligence on judgment and decision making, Military Operational Medicine Research Program Task Area C, R & A Briefing, Walter Reed Army Institute of Research, Silver Spring, MD [Invited Lecture]

2011 Lecture Entitled: Effects of bright light therapy on sleep, cognition, brain function, and neurochemistry following mild traumatic brain injury, Military Operational Medicine Research Program Task Area C, R & A Briefing, Walter Reed Army Institute of Research, Silver Spring, MD [Invited Lecture]

2012 Oral Symposium Presentation: Shared and distinctive patterns of cortico-limbic activation across anxiety disorders, 32nd Annual Conference of the Anxiety Disorders Association of America, Arlington, VA [Invited Symposium]
2012 Lecture Entitled: Effects of bright light therapy on sleep, cognition, brain function, and neurochemistry following mild traumatic brain injury, Military Operational Medicine Research Program In Progress Review (IPR) Briefing, U.S. Army Medical Research and Materiel Command, Fort Detrick, MD [Invited Lecture]

2013 Lecture entitled Brain responses to visual images of food: Could your eyes be the gateway to excess? Presented to the NIH Nutrition Coordinating Committee and the Assistant Surgeon General of the United States, Bethesda, MD [Invited Lecture]

2013 Lecture Entitled: Update on the Effects of Bright light therapy on sleep, cognition, brain function, and neurochemistry following mild traumatic brain injury, Military Operational Medicine Research Program In Progress Review (IPR) Briefing, U.S. Army Medical Research and Materiel Command, Fort Detrick, MD [Invited Lecture]

2013 Lecture Entitled: Internet Based Cognitive Behavioral Therapy: Effects on Depressive Cognitions and Brain Function, Military Operational Medicine Research Program In Progress Review (IPR) Briefing, U.S. Army Medical Research and Materiel Command, Fort Detrick, MD [Invited Lecture]

2013 Symposium Entitled: Predicting Resilience Against Sleep Loss, United States Military Academy at West Point, West Point, NY [Invited Symposium].

2014 Symposium Entitled: Operating Under the Influence: The Effects of Sleep Loss and Stimulants on Decision-Making and Performance, Invited Faculty Presenter at the 34th Annual Cardiothoracic Surgery Symposium (CREF), San Diego, CA [Invited Symposium].

2014 Symposium Entitled: The Effects of Sleep Loss on Food Preference, SLEEP 2014, Minneapolis, MN [Invited Symposium]

2014 Lecture Entitled: Internet Based Cognitive Behavioral Therapy: Effects on Depressive Cognitions and Brain Function, Military Operational Medicine Research Program In Progress Review (IPR) Briefing, U.S. Army Medical Research and Materiel Command, Fort Detrick, MD [Invited Lecture]

International


2001 Oral Platform Presentation: Sex differences in functional activation of the amygdala during the perception of happy faces, 29th Annual Meeting of the International Neuropsychological Society, Chicago, IL.
2002 Oral Platform Presentation: Developmental changes in the lateralized activation of the prefrontal cortex and amygdala during the processing of facial affect, 30th Annual Meeting of the International Neuropsychological Society, Toronto, Ontario, Canada.


2008 Lecture on Sleep Deprivation, Executive Function, & Resilience to Sleep Loss, First Franco-American Workshop on War Traumatism, IMNSSA, Toulon, France [Invited Lecture]

2012 Oral Platform Presentation: Shared and unique patterns of cortico-limbic activation across anxiety disorders. 40th Meeting of the International Neuropsychological Society, Montreal, Canada.

Report of Clinical Activities and Innovations

Current Licensure and Certification
2001- Clinical Psychologist, New Hampshire

Practice Activities
1991- 1995 Psychology, Clinical, Psychology Clinic, Texas Tech University, Lubbock, TX
Clinical Activity Description: Provided psychotherapy and other supervised psychological services for a broad spectrum of client problems. Duties included regular therapy contacts with four to eight clients per week for approximately four years. Clients ranged in age from preschool through middle age. Clinical responsibilities included intake evaluations, formal testing and assessment, case formulation and treatment plan development, and delivery of a wide range of psychotherapy services including crisis intervention, behavior modification, short-term cognitive restructuring, and long-term psychotherapy.
Patient Load: 6/week

1993- 1995 Psychology, Neuropsychology, Methodist Hospital Rehabilitation Institute, Lubbock, TX
Clinical Activity Description: A two year placement consisting of two days per week within a large rehabilitation unit of a major regional medical center. Responsibilities included administration, scoring, and writing of neuropsychological assessments/reports, primarily emphasizing the Halstead-Reitan Neuropsychological Battery. Assessment services were provided on both inpatient and outpatient basis.
Patient Load: 2/week

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1995-1996 Psychology, Neuropsychology, Yale University School of Medicine, Connecticut Mental Health Center
Clinical Activity Description: Neuropsychological and psychodiagnostic assessment of chronic and severe mentally ill patients. Duties included patient interviewing, test administration, scoring, interpretation, and report writing. Assessment and consultation services were provided for both the inpatient and outpatient units.
Patient Load: 2/week

1995-1996 Psychology, Clinical, Yale University School of Medicine, West Haven Mental Health Clinic
Clinical Activity Description: Provided short-term, long-term, and group psychotherapy services, consultation, and psychological assessments for adults, children, and families. Duties also included co-leading a regular outpatient group devoted to treatment of moderate to severe personality disorders.
Patient Load: 12/week

1996-1997 Psychology, Neuropsychology, University of Oklahoma Health Sciences Center
Clinical Activity Description: Full-time placement in the Neuropsychological Assessment Laboratory, which meets INS/Division 40 guidelines for post-doctoral training in clinical neuropsychology. Responsibilities included comprehensive neuropsychological assessment and consultation services, including test administration, scoring, interpretation, and report writing. Regular outpatient psychotherapy was also provided for approximately two patients per week.
Patient Load: 4/week

1997-1999 Psychology, Neuropsychology, University of Pennsylvania Medical Center
Clinical Activity Description: Full-time two-year placement in the Department of Neurology, which meets INS/Division 40 guidelines for post-doctoral training in clinical neuropsychology. Responsibilities included neuropsychological assessment, consultation, and psychotherapy services for the Departments of Neurology and Neurosurgery.
Patient Load: 3/week

Report of Education of Patients and Service to the Community

Recognition
Report of Scholarship

Publications

Peer reviewed publications in print or other media

A) Research Investigations:


B) Other Peer Reviewed Publications


Non-peer reviewed scientific or medical publications/materials in print or other media

Reviews/Chapters/Editorials


15. **Killgore, WD.** Sleep deprivation and behavioral risk taking. In Watson, RR, Sleep Modulation by Obesity, Diabetes, Age and Diet. Elsevier (in press).

**Published U.S. Government Technical Reports**


**Professional educational materials or reports, in print or other media**

1. **Killgore, WD, & Bailey, JD.** Sleep History And Readiness Predictor (SHARP). Silver Spring, MD: Walter Reed Army Institute of Research; 2006. Computer program for predicting cognitive status based on actigraphically recorded sleep history. Patent Pending.

**Thesis**

1. **Killgore, WD.** Senior Honors Thesis: Perceived intensity of lateral facial asymmetry of spontaneous vs. posed emotional expressions. Albuquerque, NM: University of New Mexico;1990. *(Outstanding Psychology Senior Honors Thesis, UNM-1990)*.


Abstracts, Poster Presentations and Exhibits Presented at Professional Meetings


2. **Killgore, WDS, & Locke, B.** A nonverbal instrument for the measurement of transient mood states: The Facial Analogue Mood Scale (FAMS) [Abstract]. Proceedings of the Annual Conference of the Oklahoma Center for Neurosciences 1996, Oklahoma City, OK.


52. **Killgore, WDS, Balkin, TJ, & Wesensten, NJ.** Decision-making is impaired following 2-days of sleep deprivation. Poster presented at the 34th Meeting of the International Neuropsychological Society, Boston, MA, February 1-4, 2006.


59. Huck, NO, Kendall, AP, McBride, SA, **Killgore, WDS.** The perception of facial emotion is enhanced by psychostimulants following two nights of sleep deprivation [abstract]. Abstract presented at the 20th Meeting of the Associated Professional Sleep Societies, Salt Lake City, UT, June 17-22, 2006. SLEEP, 29 (Supplement), A136.

60. O’Sullivan, M, Reichardt, RM, Krugler, AL, Killgore, DB, & **Killgore, WDS.** Premorbid intelligence correlates with duration and quality of recovery sleep following sleep deprivation [abstract]. Abstract presented at the 20th Meeting of the Associated Professional Sleep Societies, Salt Lake City, UT, June 17-22, 2006. SLEEP, 29 (Supplement), A372.


72. Killgore, DB, Kahn-Green, E, Balkin, TJ, Kamimori, GH, & Killgore, WDS. 56 hours of wakefulness is associated with a sub-clinical increase in symptoms of psychopathology [abstract]. Abstract presented at the 20th Meeting of the Associated Professional Sleep Societies, Salt Lake City, UT, June 17-22, 2006. SLEEP, 29 (Supplement), A130.


74. Reichardt, RM, Killgore, DB, Lipizzi, EL, Li, CJ, Krugler, AL, & Killgore, WDS. The effects of stimulants on recovery sleep and post-recovery verbal performance following 61-hours of sleep deprivation [abstract]. Abstract presented at the 20th Meeting of the Associated Professional Sleep Societies, Salt Lake City, UT, June 17-22, 2006. SLEEP, 29 (Supplement), A42.

75. Bailey, JD, Richards, J, & Killgore, WDS. Prediction of mood fluctuations during sleep deprivation with the SAFTE Model [abstract]. Abstract presented at the 20th Meeting of the Associated Professional Sleep Societies, Salt Lake City, UT, June 17-22, 2006. SLEEP, 29 (Supplement), A60.

76. Kendall, AP, McBride, S. A, & Killgore, WDS. Visuospatial perception of line orientation is resistant to one night of sleep loss [abstract]. Abstract presented at the 20th Meeting of the Associated Professional Sleep Societies, Salt Lake City, UT, June 17-22, 2006. SLEEP, 29 (Supplement), A369.

77. Kendall, AP, McBride, SA, Kamimori, GH, & Killgore, WDS. The interaction of coping skills and stimulants on sustaining vigilance: Poor coping may keep you up at night [abstract]. Abstract presented at the 20th Meeting of the Associated Professional Sleep Societies, Salt Lake City, UT, June 17-22, 2006. SLEEP, 29 (Supplement), A129.

78. Muckle, A, Killgore, DB, & Killgore, WDS. Gender differences in the effects of stimulant medications on the ability to estimate unknown quantities when sleep deprived [abstract]. Abstract presented at the 20th Meeting of the Associated Professional Sleep Societies, Salt Lake City, UT, June 17-22, 2006. SLEEP, 29 (Supplement), A369.


89. Richards, JM, Lipizzi, EL, Kamimori, GH, & Killgore, WD. Extroversion predicts change in attentional lapses during sleep deprivation [abstract]. Abstract presented at the 21st Meeting of the Associated Professional Sleep Societies, Minneapolis, MN, June 9-14, 2007. SLEEP, 30 (Supplement), A137.
90. Lipizzi, EL, Richards, JM, Balkin, TJ, Grugle, NL, & Killgore, WD. Morningness-Eveningness and Intelligence [abstract]. Abstract presented at the 21st Meeting of the Associated Professional Sleep Societies, Minneapolis, MN, June 9-14, 2007. SLEEP, 30 (Supplement), A345.


98. Rupp, TL, Grugle, NL, Krugler, AL, Balkin, TJ, & Killgore, WD. Caffeine, dextroamphetamine, and modafinil improve PVT performance after sleep deprivation and recovery sleep [abstract]. Abstract presented at the 21st Meeting of the Associated Professional Sleep Societies, Minneapolis, MN, June 9-14, 2007. SLEEP, 30 (Supplement), A44.

100. **Killgore, WD**, Richards, JM, Balkin, TJ, Grugle, NL, & Killgore DB. The effects of sleep deprivation and stimulants on risky behavior [abstract]. Abstract presented at the 21st Meeting of the Associated Professional Sleep Societies, Minneapolis, MN, June 9-14, 2007. SLEEP, 30 (Supplement), A41.


102. Richards, JM, Lipizzi, EL, Balkin, TJ, Grugle, NL, & **Killgore, WD**. Objective alertness predicts mood changes during 44 hours of sleep deprivation [abstract]. Abstract presented at the 21st Meeting of the Associated Professional Sleep Societies, Minneapolis, MN, June 9-14, 2007. SLEEP, 30 (Supplement), A56.


104. Estrada, A, **Killgore, WD**, Rouse, T, Balkin, TJ, & Wildzunas, RM. Total sleep time measured by actigraphy predicts academic performance during military training [abstract]. Abstract presented at the 22nd Meeting of the Associated Professional Sleep Societies, Baltimore, MD, June 7-12, 2008. SLEEP, 31 (Supplement), A134.


107. Reid, CT, Smith, K, **Killgore, WD**, Rupp, TL, & Balkin, TJ. Higher intelligence is associated with less subjective sleepiness during sleep restriction [abstract]. Abstract presented at the 22nd Meeting of the Associated Professional Sleep Societies, Baltimore, MD, June 7-12, 2008. SLEEP, 31 (Supplement), A375.


123. Killgore, WD, Killgore, DB, Kamimori, GH, & Balkin, TJ. When being smart is a liability: More intelligent individuals may be less resistant to sleep deprivation. Abstract presented the 37th Annual Meeting of the International Neuropsychological Society, Atlanta, GA, February 11-14, 2009.


142. **Killgore, WD & Balkin, TJ.** Vulnerability to sleep loss is affected by baseline executive function capacity. Abstract presented at the 38th Annual Meeting of the International Neuropsychological Society, Acapulco, Mexico, February 3-6, 2010.


146. **Killgore, WD & Yurgelun-Todd, DA.** Self-reported insomnia is associated with increased activation within the default-mode network during a simple attention task. Abstract presented at the 38th Annual Meeting of the International Neuropsychological Society, Acapulco, Mexico, February 3-6, 2010.


225. **Killgore WD**. Multimodal neuroimaging to predict cognitive resilience against sleep loss. Abstract presented at the DARPA Young Faculty Award 2012 Meeting, Arlington, VA, July 30-31, 2012. [*Winner Young Faculty Award in Neuroscience*]


My research has emphasized the study of higher order cognition and executive functions and how these cognitive abilities are influenced and guided by subtle affective processes. Over the past 12 years, my research has utilized functional and structural magnetic resonance imaging to study the interaction of affective processes and cognition within limbic networks of the medial temporal lobes and prefrontal cortex. This line of research has led to the refinement of a developmental model of prefrontal cortical-limbic maturation that explains how these processes contribute to the way adolescents perceive emotionally and motivationally relevant stimuli such as affective faces and visual images of food. As a result of the Iraq War, I took an extended leave of absence to serve in the Active Duty Army as the Chief of the Neurocognitive Performance Branch at the Walter Reed Army Institute of Research from 2002-2007. During that time, I extended the scope of my affective processing research to also examine the effects of stressors such as prolonged sleep deprivation, chronic sleep restriction, nutritional deprivation, and the use of stimulant countermeasures on the cognitive-affective systems within the brain. This line of investigation suggests that sleep deprivation alters the metabolic activity within the medial prefrontal cortex, resulting in subtle but profound effects on specific aspects of cognition. These sleep-loss related prefrontal decrements impair the ability to use affective processes to guide judgment and decision-making, particularly in high-risk or morally relevant situations. My recent investigations also suggest that while commonly used stimulants such as caffeine, modafinil, and dextroamphetamine are highly effective at reversing sleep-loss induced deficits in alertness and vigilance, they have virtually no restorative effect on the cognitive-affective decision-making systems of the brain. Having left military service to return to McLean Hospital full time in the summer of 2007, I have since been extending my previous work to identify the extent to which these cognitive-affective decision-making systems and their neurobiological substrates are impaired or altered in patients suffering from anxiety disorders and post-traumatic stress. During the past five years I have also successfully secured multiple grants from the DoD and DARPA totaling more than $7.8M, including a study of the neural basis of emotional intelligence, a study of a novel light treatment for improving sleep and cognitive functioning in mTBI, and a neuroimaging study of the effectiveness of an internet based cognitive-behavior therapy program, a neuroimaging study of axonal damage in mTBI, and a study of the neural basis of resilience against the adverse effects of sleep deprivation. In early 2011, I was named Co-Director of the Social, Cognitive, and Affective Neuroscience Lab at McLean Hospital.

My recent teaching activities have primarily involved daily supervision and training of student research assistants and postdoctoral fellows, as well as occasional seminar presentations. Over the past 6 years, I have closely and regularly mentored more than 25 students at the undergraduate, graduate, and postdoctoral level. This involvement has included one-on-one supervision and training in basic research methods, neuropsychological assessment, statistical analysis, and manuscript preparation. Nearly all of my advisees have served as co-authors on abstracts, posters, talks, and published manuscripts based on my research program.