**B1: Delusion of reference**

CODE 3: When events, objects, or other persons in the individual’s immediate environment are seen as having a particular and unusual significance. [A false belief held despite what almost everyone else believes and obvious or evidence to the contrary. If the false belief involves a value judgment so extreme that it defies credibility].

CODE 2: Overvalued ideas, or, unreasonable and sustained beliefs that are maintained with less than delusional intensity

CODE 1: Belief is accepted by person’s culture or subculture.

ASK (if psychotic symptoms have been acknowledged): You’ve told me about (PSYCHOTIC SXS). Now I’d like to ask you about other experiences like that.

ASK (if psychotic symptoms have not already been acknowledged): Now I’d like to ask you about unusual experiences that people sometimes have. 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?)

ASK (if yes): Were you convinced they were talking about you or did you think it might have been your imagination?

TIP: Consider the degree of conviction held for the belief by observing facial cues, vocal tones and linguistic patterns (i.e. faster, more wordy, more tangential etc.) and level of persistence upon questioning. Ask if others have commented on (the validity of) this belief.

**B2: Persecutory delusion**

CODE 3: If patient endorses a central theme of being attacked, harassed, cheated, persecuted, or conspired against (or someone to whom one is close to).

ASK: Did you ever have the feeling that something on the radio, TV, or in a movie was meant especially for you?

ASK (if no): What about anyone going out of their way to give you a hard time, or trying   
to hurt you? Did you ever have the feeling that the words in a popular song were meant to send you a message? Did you ever have the feeling that what people were wearing was meant to send you a special message? 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?

TIP: Clarify that the feeling is not just particularly relevant to him/her, but that it was meant for him/her in particular (i.e. specifically targeted). Consider the degree of conviction held for the belief by observing facial cues, vocal tones and linguistic patterns (i.e. faster, more wordy, more tangential etc.) and level of persistence upon questioning.

**B3: Grandiose delusion**

CODE 3: If content patient endorses involves inflated worth, power, knowledge identity, or a special relationship to a deity or famous person.

ASK: Have you ever thought that you were especially important in some way,   
or that you had special powers? Or, did you ever believe that you had a special or close relationship with a celebrity or someone else famous?

TIP: Consider the degree of conviction held for the belief by observing facial cues, vocal tones and linguistic patterns (i.e. faster, more wordy, more tangential etc.) and level of persistence upon questioning. Ask if others have commented on (the validity of) this belief.

**B4: Somatic delusion**

CODE 3: When the main content pertains to the appearance or functioning of one’s body

ASK: Have you ever felt that something was very wrong with you physically even though your doctor said nothing was wrong . . . like you had cancer or some other disease? Or, have you ever been convinced that something was very wrong with the way a part or parts of your body looked? Or, have you ever felt that something strange was happening to parts of your body?

TIP: Ask about having previous medical condition and if they have seen a doctor about their complaint. Consider the degree of conviction held for the belief by observing facial cues, vocal tones and linguistic patterns (i.e. faster, more wordy, more tangential etc.) and level of persistence upon questioning. Ask if others have commented on (the validity of) this belief.

**B5: Religious delusion**

CODE 3: If patient endorses a delusion with a religious or spiritual content

ASK: Are you a religious or spiritual person?

ASK (if yes): Are you a religious or spiritual person?

ASK (if yes): Have you ever had any religious or spiritual experiences that the other people in your religious or spiritual community have not experienced?

ASK (if yes): What did they think about these experiences of yours?

ASK (if no): Have you ever felt that God, or the devil, or some other deity had communicated directly with you?

TIP: If experience not part of religion; ask their religion -- maybe belief part of subculture. Consider the degree of conviction held for the belief by observing facial cues, vocal tones and linguistic patterns (i.e. faster, more wordy, more tangential etc.) and level of persistence upon questioning. Ask if others have commented on (the validity of) this belief.

**B6: Delusion of guilt**

CODE 3: If patient endorses 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

ASK: Have you ever felt that you had committed a crime or done something terrible for which you should be punished? Or, have you ever felt that something you did, or should have done, but did not do, caused serious harm to your parents, children or other family members?

TIP: [[Ask if normal tasks, such as getting dressed or basic hygiene, seemed too taxing or exhausting. Ask about frequency.]] Ask about retention of social contacts/friends, whether or not they have become less close with their family during this period, or if they have been unable to keep a job. Consider the degree of conviction held for the belief by observing facial cues, vocal tones and linguistic patterns (i.e. faster, more wordy, more tangential etc.). Ask if others have commented on (the validity of) this belief.

**B7: Jealous delusion**

CODE 3: If content of thought is that one’s sexual partner is unfaithful (without any evidence)

ASK: Have you ever been convinced that your spouse or partner was being unfaithful to you?

ASK (if yes): How did you know they were being unfaithful?

TIP: Ask if there is any evidence for this belief or determine if the belief persists in light of disconfirming evidence. Consider the degree of conviction held for the belief by observing facial cues, vocal tones and linguistic patterns (i.e. faster, more wordy, more tangential etc.) and level of persistence upon questioning. Ask if others have commented on (the validity of) this belief.

**B8: Erotomanic delusion**

CODE 3: If thought is that another person, usually of higher status, is in love with the individual.

ASK: Did you ever have a “secret admirer” who, when you tried to contact them, denied that they were in love with you? Or, did you ever think that you had a secret relationship with someone famous?”

TIP: Consider the degree of conviction held for the belief by observing facial cues, vocal tones and linguistic patterns (i.e. faster, more wordy, more tangential etc.) and level of persistence upon questioning. Ask if others have commented on (the validity of) this belief.

**B9: Delusion of being controlled**

CODE 3: If feelings, impulses, thoughts, or actions are experienced as being under the control of some external force rather than under one’s own control.

ASK: Did you ever feel that someone or something outside yourself was controlling your thoughts or actions against your will?

TIP: Ask about retention of social contacts/friends, whether or not they have become less close with their family during this period, or if they have been unable to keep a job. Consider the degree of conviction held for the belief by observing facial cues, vocal tones and linguistic patterns (i.e. faster, more wordy, more tangential etc.) and level of persistence upon questioning. Ask if others have commented on (the validity of) this belief.

**B10: Thought insertion**

CODE 3: If it is believed that certain thoughts are not his/her own, but rather inserted into his/her mind.

ASK: Did you ever feel that certain thoughts that were not your own were put into your head?

TIP: Ask about retention of social contacts/friends, whether or not they have become less close with their family during this period, or if they have been unable to keep a job. Consider the degree of conviction held for the belief by observing facial cues, vocal tones and linguistic patterns (i.e. faster, more wordy, more tangential etc.) and level of persistence upon questioning. Ask if others have commented on (the validity of) this belief.

**B11: Thought withdrawal**

CODE 3: If it is believed that one’s thoughts have been “removed” by some outside force.

ASK: What about taken out of your head?

TIP: Ask about retention of social contacts/friends, whether or not they have become less close with their family during this period, or if they have been unable to keep a job. Consider the degree of conviction held for the belief by observing facial cues, vocal tones and linguistic patterns (i.e. faster, more wordy, more tangential etc.) and level of persistence upon questioning. Ask if others have commented on (the validity of) this belief.

**B12: Thought broadcasting**

CODE 3: If it is believed that the delusion that one’s thoughts are being broadcast out loud and can be perceived by others.

ASK: Did you ever feel as if your thoughts were being broadcast out loud so that other people could actually hear what you were thinking? Did you ever believe that someone could read your mind?

TIP: Ask about retention of social contacts/friends, whether or not they have become less close with their family during this period, or if they have been unable to keep a job. Consider the degree of conviction held for the belief by observing facial cues, vocal tones and linguistic patterns (i.e. faster, more wordy, more tangential etc.) and persistence upon questioning. Ask if others have commented on (the validity of) this belief.

**B13: Other delusions**

CODE 3: For other delusions, such as nihilistic delusions (e.g. conviction that a major catastrophe will occur)

ASK: NO ACCOMPANYING QUESTION IN SCID

TIP: Ask about retention of social contacts/friends, whether or not they have become less close with their family during this period, or if they have been unable to keep a job. Consider the degree of conviction held for the belief by observing facial cues, vocal tones and linguistic patterns (i.e. faster, more wordy, more tangential etc.) and level of persistence upon questioning. Ask if others have commented on (the validity of) this belief.

**B14: Bizarre delusion**

CODE 3: If a phenomenon that the person’s culture would regard as physically impossible (e.g., the person’s brain has been removed and replaced with someone else’s brain) is endorsed.

ASK (if delusional): How do you explain (CONTENT OF DELUSION)?

TIP: Code based on content of delusions coded “3.” A rating of “3” on any of B9-B12 should be counted as a bizarre delusion here. Bizarre delusions are those that do not derive from ordinary life experiences. Delusions expressing a loss of control over mind or body are bizarre. Bizarre delusions are implausible to same-culture peers and do not derive from ordinary life experiences.

**B15: Severity (of delusion) past 7 days**

CODE 0 = Not present

CODE 1 = Equivocal (severity or duration not sufficient to be considered psychosis)

CODE 2 = Present, but mild (little pressure to act upon delusional beliefs, not very bothered by delusions)

CODE 3 = Present and moderate (some pressure to act upon beliefs, the person is somewhat preoccupied by beliefs or is somewhat bothered by beliefs)

CODE 4 **=** Present and severe (severe pressure to act upon beliefs, is completely preoccupied by beliefs or is very bothered by beliefs)

ASK (if unknown): In the past week, how bothered have you been by these ideas? Did you do anything because of them?

TIP: Assess level of insight and the persistence for the belief when confronted with disconfirming evidence, or if individual becomes hostile/defensive upon confrontation or questioning (from interviewer or others). Consider the complexity of the delusion.

**B16: Lifetime Severity (of delusion)**

CODE 0 = Not present

CODE 1 = Equivocal (severity or duration not sufficient to be considered psychosis)

CODE 2 = Present, but mild (little pressure to act upon delusional beliefs, not very bothered by delusions)

CODE 3 = Present and moderate (some pressure to act upon beliefs, the person is somewhat preoccupied by beliefs or is somewhat bothered by beliefs)

CODE 4 **=** Present and severe (severe pressure to act upon beliefs, is completely preoccupied by beliefs or is very bothered by beliefs)

ASK: During that time, how bothered were you by these ideas? Did you do anything about them?

TIP: FOCUS ON PERIOD OF TIME WHEN SUBJECT WAS MOST IMPAIRED OR SYMPTOMS WERE MOST SEVERE (CONSIDER INFORMATION FROM OVERVIEW)

**B17: Auditory hallucinations**

CODE 3: (i.e., involving the perception of sound, most commonly of voice) When fully awake, (perception of sound) heard either inside or outside of the head.

CODE 2: FOR HALLUCINATIONS THAT ARE SO TRANSIENT AS TO BE WITHOUT DIAGNOSTIC SIGNIFICANCE.

CODE 1: FOR HYPNAGOGIC (while falling asleep) OR HYPNOPOMPIC (while waking up) HALLUCINATIONS, OCCURING WHEN FALLING SLEEP OR UPON AWAKENING

ASK: 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?)

ASK (if yes): What did you hear? How often did you hear it?

TIP: Code “3” if the sound (hallucination) is involuntary and if the individual reports a lack of control over the perceptual experience. Assess if it was driven by an external stimulus and the clarity of the sound. Ask if perceived as distinct from his/her own thoughts. Assess level of insight into the source of the sound. Determine if only occurs when falling asleep/waking up. Ask if others have commented on (the validity of) this experience. Consider the complexity of the hallucination.

**B18: Visual hallucinations**

CODE 3: Patient experiences hallucination involving sight, which may consist of formed images, such as of people or of unformed images, such as flashes of light.

ASK: Did you have visions or see things that other people couldn’t see? (Were you awake at the time?)

ASK (if yes): What did you hear? How often did you hear it?

TIP: Distinguish from an illusion, i.e., a misperception of a real external stimulus. Code “3” if the hallucination is involuntary, or if there is a lack of control over the perception. Ask if perceived as distinct from his/her own thoughts. Assess level of insight into the source of the vision.

**B19: Tactile hallucinations**

CODE 3: Patient experiences a hallucination involving the perception of being touched or of something being under one’s skin.

ASK: What about strange sensations on your skin, like electric shocks or feeling like something is creeping or crawling on or under your skin?

TIP: Distinguish from an illusion, i.e., a misperception of a real external stimulus. Code “3” if the touch sensation (hallucination) is involuntary and if the individual reports a lack of control over the perceptual experience. Assess level of insight into the source of the sensation.

**B20: Somatic hallucinations**

CODE 3: Patient experiences a hallucination involving the perception of physical experience localized within the body (e.g., a feeling of electricity).

ASK: What about having unusual sensations inside a part of your body?

TIP: Distinguish from an illusion, i.e., a misperception of a real external stimulus. Code “3” if the touch sensation (hallucination) is involuntary and if the individual reports a lack of control over the perceptual experience. Assess level of insight into the source of the sensation.

**B21: Gustatory hallucinations**

CODE 3: Patient experiences a hallucination involving the perception of taste (usually unpleasant)

ASK: How about tasting things that other people couldn’t taste?

TIP: Distinguish from an illusion, i.e., a misperception of a real external stimulus. Code “3” if the gustatory sensation (hallucination) is involuntary and if the individual reports a lack of control over the perceptual experience. Assess if it was driven by an external stimulus or only occurs around food intake.

**B22: Olfactory hallucinations**

CODE 3: Patient experiences a hallucination involving the perception of odor

ASK: What about smelling things that other people couldn’t smell, like burning rubber or decaying food?

TIP: Typically suggestive of temporal lobe epilepsy – determine if s/he has received medical treatment/diagnosis. Distinguish from an illusion, i.e., a misperception of a real external stimulus. Code “3” if the olfactory experience (hallucination) is involuntary and if the individual reports a lack of control over the perceptual experience. Assess level of insight into the source of the sensation.

**B23: Severity (of hallucinations) past 7 days**

CODE 0 = Not present

CODE 1 = Equivocal (severity or duration not sufficient to be considered psychosis)

CODE 2 = Present, but mild (little pressure to act upon voices or other hallucinations, not very bothered by voices or other hallucinations

CODE 3 = Present and moderate (some pressure to respond to voices, or is somewhat bothered by voices or other hallucinations)

CODE 4 **=** Present and severe (severe pressure to respond to voices or other hallucinations, or is very bothered by voices or other hallucinations)

ASK (if unknown): In the past week, how much did (HALLUCINATION) bother you? Did you do anything because of (HALLUCINATIONS)?

ASK (if visual or auditory hallucination): Did you talk to (HALLUCINATION)?

ASK (if voices): If the voices told you do something, did you do it?

TIP: Consider the degree of conviction held for the hallucination by observing facial cues, vocal tones and linguistic patterns (i.e. faster, more wordy, more tangential etc.). Assess if individual becomes hostile/defensive upon confrontation or questioning about perceptual experience. Consider the complexity of the hallucination.

**B24: Lifetime severity (of hallucination)**

CODE 0 = Not present

CODE 1 = Equivocal (severity or duration not sufficient to be considered psychosis)

CODE 2 = Present, but mild (little pressure to act upon voices or other hallucinations, not very bothered by voices or other hallucinations

CODE 3 = Present and moderate (some pressure to respond to voices, or is somewhat bothered by voices or other hallucinations)

CODE 4 **=** Present and severe (severe pressure to respond to voices or other hallucinations, or is very bothered by voices or other hallucinations)

ASK (if unknown): When in your life were (HALLUCINATIONS) the most intense? During that time, how much did (HALLUCINATION) bother you? During that time, did you do anything in response to them?

ASK (if visual or auditory hallucination): Did you talk to (HALLUCINATION)?

ASK (if voices): If the voices told you do something, did you do it?

TIP: Consider the degree of conviction held for the hallucination by observing facial cues, vocal tones and linguistic patterns (i.e. faster, more wordy, more tangential etc.). Assess if individual becomes hostile/defensive upon confrontation or questioning about perceptual experience. Consider the complexity of the hallucination(s).

**B25 – SKIP Instruction for Other Psychotic Symptoms**

**B26: Disorganized Speech**

Code 3: When the individual may switch from one topic to another (derailment or loose associations). Answers to questions may be obliquely related or completely unrelated (tangentiality). Rarely, speech may be so severely disorganized that it is nearly incomprehensible and resembles receptive aphasia in its linguistic disorganization (incoherence or “word salad”). Because mildly disorganized speech is common and nonspecific, the symptom must be severe enough to substantially impair effective communication.

* Codes based on observation and history – consult old charts, other observers, e.g. family members, therapeutic staff

ASK: Let me stop for a minute while I make a few notes . . .

TIP: Consider individual’s linguistic background and use discretion when from a different linguistic background from the interviewee. Consider how speech impacts ability to communicate effectively.

**B27: Severity (of disorganized speech) Past 7 days**

CODE 0 = Not present

CODE 1 = Equivocal (severity or duration not sufficient to be considered disorganization)

CODE 2 = Present, but mild (some difficulty following speech)

CODE 3 = Present and moderate (speech often difficult to follow)

CODE 4 = Present and severe (speech almost impossible to follow)

* Codes based on observation and history – consult old charts, other observers, e.g. family members, therapeutic staff

ASK: Let me stop for a minute while I make a few notes . . .

TIP: Consider patient’s ability to communicate effectively.

**B28: Lifetime Severity (of disorganized speech)**

CODE 0 = Not present

CODE 1 = Equivocal (severity or duration not sufficient to be considered disorganization)

CODE 2 = Present, but mild (some difficulty following speech)

CODE 3 = Present and moderate (speech often difficult to follow)

CODE 4 = Present and severe (speech almost impossible to follow)

* Codes based on observation and history – consult old charts, other observers, e.g. family members, therapeutic staff

ASK: Let me stop for a minute while I make a few notes . . .

TIP: Consider patient’s ability to communicate effectively.

**[B29: SKIPPED IN SCID-5]**

**B30: Grossly disorganized or catatonic behavior**

CODE 3: When behavior may range from childlike silliness to unpredictable agitation. The person may appear markedly disheveled, may dress in an unusual manner (e.g., wearing multiple overcoats, scarves, and gloves on a hot day), display clearly inappropriate sexual behavior (e.g., public masturbation) or unpredictable and un-triggered agitation (e.g., shouting or swearing).

* Codes based on observation and history – consult old charts, other observers, e.g. family members, therapeutic staff

ASK: Let me stop for a minute while I make a few notes . . .

TIP: Assess degree of difficulty performing activities of daily living and completing goals. Consider how behavior impacts ability to communicate effectively (and appropriately).

**B31: Catatonic Behavior - Stupor**

CODE 3: When patient displays no psychomotor activity or is not actively relating to (their) environment.

TIP: The item can be assessed by observation or by reports of informants. Consider how behavior impacts ability to communicate effectively (and appropriately).

**B32: Catatonic Behavior - Grimacing**

CODE 3: When patient displays odd and inappropriate facial expressions unrelated to situation

TIP: The item can be assessed by observation or by reports of informants. Consider how behavior impacts ability to communicate effectively (and appropriately).

**B33: Catatonic Behavior - Mannerism**

CODE 3: When patient displays odd, circumstantial caricature of normal actions.

TIP: The item can be assessed by observation or by reports of informants. Consider how behavior impacts ability to communicate effectively (and appropriately).

**B34: Catatonic Behavior - Posturing**

CODE 3: When patient displays spontaneous and active maintenance of a posture against gravity.

TIP: This item can be observed during the interview or via informant’s report. Consider how behavior impacts ability to communicate effectively (and appropriately).

**B35: Catatonic Behavior – Agitation, not influenced by external stimuli**

CODE 3: When patient displays agitation that is not influenced by external stimuli

TIP: This item can be observed during the interview or via informant’s report. Consider how behavior impacts ability to communicate effectively (and appropriately).

**B36: Catatonic Behavior - Stereotypy**

CODE 3: When patient displays repetitive, abnormally frequent, non-goal-directed movements.

TIP: This item can be observed during the interview or via informant’s report. Consider how behavior impacts ability to communicate effectively (and appropriately).

**B37: Catatonic Behavior - Mutism**

CODE 3: When patient displays no, or very little, verbal response [exclude if known aphasia].

TIP: Be sure to consult medical record. This item can be observed during the interview or via informant’s report. Consider how behavior impacts ability to communicate effectively (and appropriately).

**B38: Catatonic Behavior - Echolalia**

CODE 3: When patient mimics another’s speech

TIP: This item can be assessed during physical examination or via informant’s report. Consider how behavior impacts ability to communicate effectively (and appropriately).

**B39: Catatonic Behavior - Negativism**

CODE 3: When patient displays opposition or no response to instructions or external stimuli.

TIP: This item can be observed during the interview or via informant’s report. Consider how behavior impacts ability to communicate effectively (and appropriately).

**B40: Catatonic Behavior - Echopraxia**

CODE 3: When patient mimic’s another’s movements.

TIP: This item can be assessed during physical examination or via informant’s report. Consider how behavior impacts ability to communicate effectively (and appropriately).

**B41: Catatonic Behavior - Catalepsy**

CODE 3: When patient displays passive induction of a posture held against gravity

TIP: The item can be assessed during physical examination or via informant’s report. Consider how behavior impacts ability to communicate effectively (and appropriately).

**B42: Catatonic Behavior – Waxy Flexibility**

CODE 3: When patient displays slight, even resistance to positioning by examiner).

TIP: The item can be assessed during physical examination or via informants report. Consider how behavior impacts ability to communicate effectively (and appropriately).

**B43: Rate Severity (of Catatonic Behavior) Past 7 days**

CODE 0 **=** Not present

CODE 1 = Equivocal (severity or duration not sufficient to be considered abnormal psychomotor behavior)

CODE 2 = Present, but mild (occasional abnormal or bizarre motor behavior or catatonia)

CODE 3 = Present and moderate (frequent abnormal or bizarre motor)

CODE 4 = Present and severe (abnormal or bizarre motor)

TIP: Consider behavior during interview. Consider how behavior impacts ability to communicate effectively (and appropriately).

**B44: Rate Lifetime Severity (of Catatonic Behavior)**

CODE 0 **=** Not present

CODE 1 = Equivocal (severity or duration not sufficient to be considered abnormal psychomotor behavior)

CODE 2 = Present, but mild (occasional abnormal or bizarre motor behavior or catatonia)

CODE 3 = Present and moderate (frequent abnormal or bizarre motor)

CODE 4 = Present and severe (abnormal or bizarre motor)

TIP: Consider how behavior may/may not have impacted primary domains of functioning – occupational, social, personal.

**B45: Negative Symptoms - Avolition**

CODE 3: When patient displays an inability to initiate and persist in goal-directed activities. When severe enough to be considered pathological, avolition is pervasive and prevents the person from completing many different types of activities (e.g., work, intellectual pursuits, self-care). The item can be assessed during physical examination or via informant’s report.

ASK: Tell me how you spend your time. What are your goals? Do you spend much time just sitting, not doing anything in particular?

### ASK (if currently working): How much time do you usually spend working? How do you get there? Do you get there on your own? Do you start the work yourself or do you wait for others to tell you what to do?

### ASK (if currently in school): How much time do you usually spend in school or studying? How do you get there? Do you get there on your own? Do you wait for others to tell you what to do, or do you start schoolwork yourself?

ASK (if not currently working or going to school): Have you looked for work? How about looking into taking classes?

ASK (if yes): Did someone suggest it, or did you do that on your own?

### ASK (if in a treatment program): Did you participate in group activities in your treatment program?

ASK (if yes): Did someone encourage you to do that, or did you do it on your own?

### ASK: Do you spend much time watching TV?

### ASK (if yes): Are you interested in what you watch, or are you just passing the time?)

ASK: How often have you showered/bathed over the past week? How often did you clean your {apartment, room, house}? Did someone need to remind you do this?

TIP: Ask about retention of social contacts/friends, whether or not they have become less close with their family during this period, or if they have been unable to keep a job.

**B46: Negative Symptoms - Avolition – Primary/Secondary [when B45 is coded “3”]**

CODE 3: If the (negative) symptom is definitely primary

CODE 1: If the (negative) symptom is possibly or definitely secondary, i.e. related to another mental disorder (e.g. depression), a substance or another medical condition (e.g. medication-induced akinesia), or to a psychotic symptom (e.g. command hallucinations not to move)

TIP: Ask about retention of social contacts/friends, whether or not they have become less close with their family during this period, or if they have been unable to keep a job.

**B47: Negative Symptoms - Diminished Emotional Expressiveness**

CODE 3: When the patient displays reductions in the expression of emotions in the face, eye contact, intonation of speech (prosody), and movements of the hand, head, and face that normally give an emotional emphasis to speech.

TIP: Consider how the negative symptom impacts primary domains of functioning – social, occupational and personal. Observe facial cues, vocal tones and linguistic patterns (i.e. faster, more wordy, more tangential etc.) when discussing different contexts.

**B47A\*: Negative Symptoms - Diminished Emotional Expressiveness – Primary/Secondary (\*labeled B35 in SCID)**

CODE 3: If the (negative) symptom is definitely primary

CODE 1: If the (negative) symptom is possibly or definitely secondary, i.e. related to another mental disorder (e.g. depression), a substance or another medical condition (e.g. medication-induced akinesia), or to a psychotic symptom (e.g. command hallucinations not to move)

TIP: Consider how the negative symptom impacts primary domains of functioning – social, occupational and personal. Consider facial cues, vocal tones and linguistic patterns (i.e. faster, more wordy, more tangential etc.).

**B48: Rate Severity (of Diminished Emotional Expressiveness) Past 7 Days**

CODE 0: (Symptom) Not present

CODE 1: When patient displays equivocal decrease in facial reciprocity, prosody, gestures, or self-initiated behavior

CODE 2 = When symptom is present, but mild (mild decrease in facial expressivity, prosody, gestures, or self-initiated behavior)

CODE 3 = When symptom is present and moderate (moderate decrease in facial expressivity, prosody, gestures, or self-initiated behavior)

CODE 4 = When symptom is present and severe (severe decrease in facial expressivity, prosody, gesture, or self-initiated behavior)

TIP: Consider how the negative symptom impacts primary domains of functioning – social, occupational and personal. Consider facial cues, vocal tones and linguistic patterns (i.e. faster, more wordy, more tangential etc.).

**B49: Rate Lifetime Severity (of Diminished Emotional Expressiveness)**

CODE 0: (Symptom is) Not present

CODE 1: When patient displays equivocal decrease in facial reciprocity, prosody, gestures, or self-initiated behavior

CODE 2: When symptom is present, but mild (mild decrease in facial expressivity, prosody, gestures, or self-initiated behavior)

CODE 3: When symptom is present and moderate (moderate decrease in facial expressivity, prosody, gestures, or self-initiated behavior)

CODE 4: When symptom is present and severe (severe decrease in facial expressivity, prosody, gesture, or self-initiated behavior)

TIP: Consider how the negative symptom has impacted the primary domains of functioning – social, occupational and personal. Consider facial cues, vocal tones and linguistic patterns (i.e. faster, more wordy, more tangential etc.).

**B50-B74: Chronology of Psychotic Symptoms Coded “3”**

ASK questions like: When did (SYMPTOMS) begin? ASK (if not currently present): When did they last occur?

**C1: Skip Instruction [Differential Diagnosis of Psychotic Disorders]**

**C2: Psychotic Mood Disorder vs. (Ruled Out) Non-Mood Psychotic Disorder**

CODE 1: If psychotic symptoms occur only during major depressive episodes with a [1] (depressed mood) or manic episodes.

CODE 3: If no major depressive or manic episodes, or if some psychotic symptoms occur outside of mood episodes, or if psychotic symptoms occur only during major depressive episodes that lack a (1) depressed mood.

ASK (if a major depressive or manic episode has ever been present): Has there ever been a time when you had (PSYCHOTIC SXS) and you were not (DEPRESSED/MANIC)?

TIP:

**C3: Schizophrenia Criteria (Presence of Active Phase Symptoms)**

Refer to items coded 3 in the psychotic and associated symptoms module (module b)

TIP: Consider a rating of “1” if delusions plus hallucinations consist only of delusions plus tactile and/or olfactory hallucinations that are thematically related to the delusions (which is consistent with a diagnosis of delusional disorder).

Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated): At least one of these must be (1 - delusions), (2 - hallucinations), or (3 – disorganized speech).

**C4: Schizoaffective Disorder and Depressive or Bipolar Disorder with Psychotic Features have been ruled out Part 1 [concurrent depression or mania with psychotic symptoms]**

CODE 3: If never any major depressive or manic episodes or if all major depressive and manic episodes occurred during the prodromol or residual phase.

CODE 1: If any mood episodes overlap with psychotic symptoms.

ASK (if unclear): Has there ever been a time when you had (SXS FROM ACTIVE PHASE) at the same time that you were (down/ high/irritable/OWN WORDS)?

TIP: Because of the difficulty in distinguishing the prodromal and residual symptoms of schizophrenia from a major depressive syndrome, reconsider any previously coded major depressive episode to be sure it is unequivocal

**C5**: **Schizoaffective Disorder and Depressive or Bipolar Disorder with Psychotic Features have been ruled out Part 2 [mood episodes are a minority of the duration of the psychotic symptoms, residual or active]**

CODE 1: only if symptoms meeting criteria for a major depressive or manic episode have been present for a majority of the total duration of the active and residual phases.

ASK (if unclear): How much of the time that you have had (SXS FROM ACTIVE AND RESIDUAL PHASES) would you say you have also been (depressed/high/ irritable/OWN WORDS)?

**C6: Differential Diagnosis between Schizophrenia and Schizophreniform Disorder**

CODE 3: When continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet criterion A (i.e., active-phase symptoms), and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms (i.e., diminished emotional expression or avolition) or two or more symptoms listed in criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

TIP:

**C7: Functioning since onset of disturbance**

CODE 3: For a significant portion of the time since the onset of the disturbance, level of functioning in one or more major areas such as work, interpersonal relations or self-care, is markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, there is failure to achieve expected level of interpersonal, academic, or occupational functioning).

ASK (if not already known): Since you got sick, was there a period of time when you had a lot of difficulty functioning? Like being unable work or go to school, not being able to take care of yourself? How about having difficulties with family members or friends, or not wanting to be around other people?

TIP:

**C8: R/O Primary Psychotic Disorder**

CODE 3: If 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.

CODE 1: If disturbance due to substance or AMC

ASK (if not known): Were you taking any drugs or medications during this time?

ASK (if not known): Were you physically ill at this time?

TIP: If there is any indication that delusions or hallucinations may be secondary (i.e., a direct physiological consequence of AMC or substance) go to **\***AMC/SUBST**\*** C. 22, and return here to make a rating of “1” or “3.” Psychotic disorder due to another medical condition is generally not diagnosed if the individual maintains reality testing for the hallucinations (or delusions?) and appreciates that they result from the medical condition.

**C9: Condition for a DX of SZ with Autism or Communication Disorder**

CODE 3: If there is a history of autism spectrum disorder or a communication disorder of childhood onset, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations, in addition to the other required symptoms of schizophrenia, are also present for at least 1 month (or less if successfully treated).

TIP:

**C10: Schizophrenia vs. Other Specified Psychotic Disorder**

CODE 3: If schizophrenia criteria A, B, C, D, E, and F are coded “3”

TIP:

**C11: Catatonia Specifier**

CODE “with catatonia”: If full syndrome criteria for catatonia are met, i.e., at least 3 catatonia symptoms are rated “3” on pages B.8 - B.9

**C12: Schizophreniform Disorder (Criteria)**

CODE 3: If an episode of the disorder lasts at least 1 month but less than 6 months.

ASK (if not known): How long did (PSYCHOTIC SXS) last?

NOTE: Criterion C has already been rated “3” in the assessment of schizophrenia

TIP:

**C13: Primary Psychotic Disorder**

CODE 3: If the disturbance is not attributable to the direct physiological effects of a substance (e.g., a drug of abuse, medication) or to another medical condition.

CODE 1: if any other periods of psychotic sxs not due to a substance or AMC [return to C1 for that period of time]

ASK (if not known): Were you taking any drugs or medications during this time?

ASK (if not known): Were you physically ill at this time?

TIP: if there is any indication that the delusions or hallucinations may be secondary (i.e., a direct physiological consequence of amc or substance), go to **\*amc/subst\*** c. 22, and return here to make a rating of “1” or “3”. Psychotic disorder due to another medical condition is generally not diagnosed if the individual maintains reality testing for the hallucinations and appreciates that they result from the medical condition.

**C14: Schizophreniform Criteria**

CODE 3: When Schizophreniform disorder criteria “A”, “B”, “C”, and “D” are coded 3.

TIP:

**C15: Definite vs. Provisional Diagnosis of Schizophreniform**

CODE 3: If there has been a full recovery

CODE 2: If the expected recovery has not yet occurred

CODE 1: When the diagnosis is made without waiting for recovery

TIP: Determine level of insight into psychotic symptoms and observe the manner in which they discuss it (is it still a matter of concern? Do they view it as unusual and understand it is part of disorder?)

**C16: Presence of Good Prognostic Features for Schizophreniform – Onset of Psychotic Sx**

CODE 3: Onset of prominent psychotic symptoms within 4 weeks of the first noticeable change in usual behavior or functioning

TIP: Consider the level of insight into psychotic symptoms and observe the manner in which they discuss it (is it still a matter of concern? Do they view it as unusual and understand it is part of disorder?)

**C17: Presence of Good Prognostic Features for Schizophreniform – Confusion or Perplexity**

CODE 3: If presence of confusion of perplexity (in response to psychotic sx?)

TIP: Consider the level of insight into psychotic symptoms and observe the manner in which they discuss it (is it still a matter of concern? Do they view it as unusual and understand it is part of disorder?)

**C18:** **Presence of Good Prognostic Features for Schizophreniform – Premorbid Functioning**

CODE 3: If good premorbid social and occupational functioning

TIP: Consider the level of insight into psychotic symptoms and observe the manner in which they discuss it (are primary domains of function still a matter of concern? Do they view the symptoms/reductions in functioning as unusual and understand it is part of disorder?)

**C19:** **Presence of Good Prognostic Features for Schizophreniform – Absence of Blunted or Flat Affect**

CODE 3: If there is an absence of blunted or flat affect

**C20: Schizophreniform Diagnosis – Prognostic Features**

CODE 3: If at least 2 prognostic features (C16-C19) are coded “3”

**C21: Schizophreniform Diagnosis – Catatonic Specifier**

CODE 3: If full syndrome criteria for catatonia are met, i.e., at least three catatonia symptoms rated “3” on pages B.8-B.9

**C22: Schizoaffective Disorder Criteria – A**

CODE 3: If manic, mixed, or major depressive episodes with depressed mood are concurrent with “A” symptoms of schizophrenia.

CODE 1: If the only concurrent mood episodes are major depressive episodes without depressed mood (i.e., with loss of interest only)

TIP: The Major Depressive Episode must include Criterion A1: depressed mood.

**C23: Schizoaffective Disorder Criterion B**

CODE 3: If there are delusions or hallucinations for two or more weeks, in the absence of a major mood episode (depressive or manic), during the lifetime duration of the illness.

ASK (if not already known): Have there been any times when you had (PSYCHOTIC SXS) when you were not (MANIC OR DEPRESSED)?

TIP:

**C24: Schizoaffective Disorder Criterion C**

CODE 3: If symptoms that meet criteria for a major mood episode are present for the majority of the total duration of the active and residual portions of the illness.

TIP:

**C25:** **Schizoaffective Disorder Criterion D**

CODE 3: If the disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, medication) or to another medical condition.

CODE 1: If the disturbance is attributable to substance or AMC

ASK (if not known): Were you taking any drugs or medications during this time?

ASK (if not known): Were you physically ill at this time?

**C26: Schizoaffective Disorder Diagnosis**

CODE 3: If schizoaffective disorder criteria A, B, C, and D are all coded 3

TIP:

**C27: Schizoaffective Disorder Subtypes**

CODE 3: If a manic episode is part of the presentation. Major depressive episodes may also occur**.**

CODE 1: If only Major Depressive Episodes are part of the presentation.

TIP:

**C28: Schizoaffective Disorder – Catatonia Specifier**

Specify “With Catatonia” if full syndrome criteria for catatonia are met, i.e., at least 3 catatonia symptoms rated “3” on pages B.8-B.9.

**C29: SKIP Instruction for Delusional Disorder**

If there have never been any delusions, check here and skip to middle of page c.17, \*BRIEF PSYCHOTIC DISORDER\*.

**C30: Delusional Disorder Criteria – Mood Episodes Brief**

CODE 3: If there have never been any manic or major depressive episodes or if they were brief relative to the total duration of the delusional periods.

ASK (if unclear): Has there ever been a time when you have been (DELUSIONAL) at the same time that you were (depressed/high/ irritable/OWN WORDS)?

ASK (if yes): How much of the time that you have had (DELUSIONS) would you say you have also been (depressed/high/ irritable/OWN WORDS)?

TIP:

**C31: Psychotic Symptoms during Mood Episodes**

CODE 3: If the psychotic symptoms occur exclusively during Major Depressive or Manic Episodes

ASK (if unclear): Have you had (delusions) only at times when you were (depressed/high/OWN WORDS)?

TIP:

**C32: Delusional Disorder – Criterion A**

CODE 3: If there is a presence of one or more delusions (with a duration of 1 month or longer).

TIP:

**C33: Delusional Disorder – Criterion B**

CODE 3: If other active phase symptoms of schizophrenia (e.g., hallucinations) are not significant (i.e., last less than 1 month). [Or if Schizophrenia criterion A has never been met]

Note: Hallucinations, if present, are not prominent and are related to the delusional theme (e.g., the sensation of being infested with insects associated with delusions of infestation).

TIP:

**C34: Delusional Disorder Criterion C**

CODE 3: If, apart from the impact of the delusion(s) or its ramifications, functioning is not markedly impaired and behavior is not obviously odd or bizarre

TIP:

**[C35 – Skipped]**

**C36:** **Delusional Disorder – Criterion E**

CODE 3: If the disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

CODE 1: If the disturbance is due to substance or AMC

* If there is any indication that the delusions may be secondary (i.e., a direct physiological consequence of an AMC or substance), go to \*amc/subst,\* c. 22, and return here to make a rating of “1” or “3”.

ASK (if not known): Were you taking any drugs or medicines during this time?

ASK (if not known): Were you physically ill at this time?

TIP:

**C37: Delusional Disorder – differential with BDD**

CODE 3: If the disturbance is not better explained by another mental disorder, such as Body Dysmorphic Disorder or Obsessive-Compulsive Disorder.

TIP:

**C38: Delusional Disorder Diagnosis**

CODE 3: If Delusional disorder criteria A, B, C, D and E are all coded “3”

TIP:

**C39: Delusional Disorder Subtypes**

SPECIFY type on the basis of predominant theme of delusion(s), and then go to chronology;

Subtypes are:

**Persecutory:** This subtype applies when the central theme of the delusion involves the individual’s belief that he or she is being conspired against, cheated, spied on, followed, poisoned or drugged, maliciously maligned, harassed, or obstructed in the pursuit   
of long-term goals

**Jealous:** This subtype applies when the central theme of the individual’s delusion is that his or her spouse or lover is unfaithful.

**Erotomanic:** This subtype applies when the central theme of the delusion is that another person is in love with the individual.

**Somatic:** This subtype applies when the central theme of the delusion involves bodily functions or sensations.

**Grandiose:** This subtype applies when the central theme of the delusion is the conviction of having some great (but unrecognized) talent or insight or having made some important discovery.

**Mixed:** This subtype applies when no one delusional theme predominates.

**Unspecified Type:** This subtype applies when the dominant delusional belief cannot be clearly determined or is not described in the specific types (e.g., referential delusions without a prominent persecutory or grandiose component).

TIP:

**C40: Delusional Disorder – Bizarre Content Specifier**

SPECIFY if “With bizarre content” when the delusions are deemed bizarre if they are clearly implausible, not understandable, and not derived from ordinary life experiences (e.g., an individual’s belief that a stranger has removed his or her internal organs and replaced them with someone else’s organs without leaving any wounds or scars).

**C41: Brief Psychotic Disorder – Criterion A**

CODE 3: If the presence of one or more of the following symptoms: (1) delusions (2) hallucinations (3) disorganized speech (e.g. frequent derailment or incoherence) (4) grossly disorganized or catatonic behavior. 🡪 At least one of these must (1), (2), or (3).

TIP: Inquire about cultural background. Do not include a symptom if it a culturally sanctioned response.

**C42: Brief Psychotic Disorder – Criterion B**

CODE 3: If the duration of an episode of the disturbance is at least 1 day, but less than 1 month, with an eventual full return to premorbid level of functioning.

TIP:

**C43:** **Brief Psychotic Disorder – Criterion C**

CODE 3: If the disturbance is not better explained by a major depressive or bipolar disorder with psychotic features, or another psychotic disorder, such as schizophrenia or catatonia.

TIP:

**C44:** **Brief Psychotic Disorder – Due to AMC/substance**

CODE 3: If the disturbance is not attributable to the physiological effects of a substance (drugs of abuse, medication) or to another medical condition.

CODE 1: If the disturbance is due to AMC/substance

* If there is any indication that the psychotic symptoms may be secondary (i.e., a direct physiological consequence of amc or substance), go to \*amc/subst,\* c. 22, and return here to make a rating of “1” or “3”.

ASK (if not known): Were you taking any drugs or medicines during this time?

ASK (if not known): Were you physically ill at this time?

TIP: Consider type of substance and length of time between substance intake and psychotic symptom expression (i.e. high cocaine intake 🡪 psychosis within minutes, high alcohol intake 🡪 psychosis within days/weeks). Persecutory delusions often develop after use of amphetamine (or similarly acting sympathomimetic) while cannabis-induced psychotic disorder involves emotional lability, marked anxiety and persecutory delusions.

**C45: Diagnosis of Brief Psychotic Disorder**

CODE 3: If brief psychotic disorder criteria A, B and C are coded “3”.

TIP:

**C46: Brief Psychotic Disorder – Stressor Specifier**

SPECIFY “With Marked Stressor(s)(brief reactive psychosis)” if the symptoms occur in response to events that, singly or together, would be markedly stressful to almost anyone in similar circumstances in the individual’s culture.

SPECIFY “Without Marked Stressor(s)” if the symptoms do not occur in response to events that, singly or together, would be markedly stressful to almost anyone in similar circumstances in the individual’s culture.

TIP:

**C47:** **Brief Psychotic Disorder – Postpartum onset Specifier**

SPECIFY “With postpartum onset” if onset is during pregnancy or within 4 weeks postpartum

TIP:

**C48:** **Brief Psychotic Disorder – Catatonia Specifier**

SPECIFY “With Catatonia” if full syndrome criteria for catatonia are met, i.e., at least 3 catatonia symptoms are rated “3” on pages B.8-B.9.

TIP:

**C49: Other Specified Psychotic Disorder**

CODE 3: For presentations in which symptoms characteristic of a Schizophrenia Spectrum and Other Psychotic Disorder that cause clinically significant distress or impairment in social, occupational or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the Schizophrenia Spectrum and Other Psychotic disorders diagnostic class.

CODE 1: If psychotic symptoms have been present but are not diagnostically significant, for example recurrent “hallucinations” of the person’s name being called. (i.e. do not diagnose Psychotic Disorder NOS).

TIP:

**C50:** **Other Specified Psychotic Disorder – AMC/Substance**

CODE 3: If the disturbance is not attributable to the physiological effects of a substance (drugs of abuse, medication) or to another medical condition.

CODE 1: If the disturbance is attributable to the physiological effects of a substance (drugs of abuse, medication) or to another medical condition.

ASK (if not known): Were you taking any drugs or medicines during this time?

ASK (if not known): Were you physically ill at this time?

TIP:

C51: Other Specified Psychotic Disorder – Type

Specify type:

**Persistent auditory hallucinations**: occurring in the absence of any other features

**Delusions with significant overlapping mood episodes:** This includes persistent delusions with periods of overlapping mood episodes that are present for a substantial portion of the delusional disturbance (such that the criterion stipulating only brief mood disturbance in delusional disorder is not met).

**Attenuated Psychosis Syndrome:** This syndrome is characterized by psychotic-like symptoms that are below a threshold for full psychosis (e.g. the symptoms are less severe and more transient, and insight is relatively maintained).

**Delusional symptoms in partner of individual with delusional disorder**: In the context of a relationship, the delusional material from the dominant partner provides content for the delusional belief by the individual who may not otherwise entirely meet criteria for delusional disorder.

**Postpartum psychosis** that does not meet criteria for Mood Disorder With Psychotic Features, Brief Psychotic Disorder, Psychotic Disorder Due to Another Medical Condition, or a Substance/Medication-Induced Psychotic Disorder

Psychotic symptoms that have lasted for less than one month, but have not yet remitted so that the criteria for Brief Psychotic Disorder are not yet met.

Situations in which the clinician has concluded that a psychotic disorder is present but is unable to determine whether it is primary, due to another medical condition or substance/medication-induced

**Other** (describe)

**C52: Chronology of Schizophrenia, Delusional Disorder, and Schizoaffective Disorder – Past Month**

CODE 3: If criteria (psychotic/mood symptoms) meet criteria in the past month

ASK (if unclear): During the past month, have you had (PSYCHOTIC SYMPTOMS CODED “3” OR, FOR SCHIZOAFFECTIVE DISORDER, DEPRESSIVE OR MANIC SYMPTOMS CODED “3”)?

**C53: Chronology of Schizophrenia, Delusional Disorder, and Schizoaffective Disorder – Last Had Sx**

ASK: When did you last have (PSYCHOTIC SXS OR, FOR SCHIZOAFFECTIVE DISORDER, EITHER DEPRESSED MOOD, OR EUPHORIC OR IRRITABLE MOOD)?

RECORD number of months prior to interview when last had symptoms that meet full criteria for Schizophrenia, Schizoaffective Disorder, or Delusional Disorder

**C54: Chronology of Schizophrenia, Delusional Disorder, and Schizoaffective Disorder – Age of Onset of Psychotic Sx**

ASK: How old were you when you first had (PSYCHOTIC SXS)?

RECORD age at onset of psychotic symptoms (code 99 if unknown)

**C55: Chronology of Schizophrenia, Delusional Disorder, and Schizoaffective Disorder – Number of Psychotic Episodes**

ASK (if not already known): How many different periods of time did you have (PSYCHOTIC SYMPTOMS)?

RECORD number of episodes or exacerbations (CODE 99 if too numerous or indistinct to count)

**C56: For a Diagnosis of Schizophrenia – Prodromal Symptoms**

RECORD age at onset of prodromal symptoms

ASK (if not already known): What kinds of difficulties were you having before you first had (PSYCHOTIC SXS)? (How old were you when these problems started?)

**C57: Schizophrenia, Delusional Disorder, and Schizoaffective Disorder – Course Specifiers**

SELECT a specifier that best characterizes the longitudinal course of the disturbance:

**First episode, currently in acute episode:** First manifestation of the disorder meeting the defining diagnostic symptom and time criteria. An *acute episode* is a time period in which the symptom criteria are fulfilled.

**First episode, currently in partial remission:** *Partial remission* is a period of time during which an improvement after a previous episode is maintained and in which the defining criteria of the disorder are only partially fulfilled.

**First episode, currently in full remission**: *Full remission* is a period of time after a previous episode during which no disorder-specific symptoms are present.

**Multiple episodes, currently in acute episode:** Multiple episodes may be determined after a minimum of two episodes (i.e., after a first episode, a remission and a minimum of one relapse).

**Multiple episodes, currently in partial remission Multiple episodes, currently in full remission**

**Continuous:** Symptoms fulfilling the diagnostic symptom criteria of the disorder are remaining for the majority of the illness course, with sub-threshold symptom periods being very brief relative to the overall course.

**Other or Unspecified Pattern**: This specifier is used if another or unspecified course pattern has been present (or if pattern is unknown).

**C58:** **Chronology of Brief Psychotic Disorder, Schizophreniform, Psychotic Disorder Due to AMC, Substance-Induced Psychotic Disorder, or Other Specified Psychotic Disorder**

CODE 3: If meets criteria (for psychotic sxs coded “3”) in the last month

ASK (if unclear): During the past month, have you had (psychotic sxs coded “3”)?

TIP:

**C59:** **Chronology of Brief Psychotic Disorder, Schizophreniform, Psychotic Disorder Due to AMC, Substance-Induced Psychotic Disorder, or Other Specified Psychotic Disorder – Most recent episode**

ASK: When did you last have (psychotic symptoms or, for schizoaffective disorder, either depressed mood or euphoric or irritable mood)?

RECORD number of months prior to interview when last had symptoms that meet full criteria for Schizophreniform, Brief Psychotic Disorder, Psychotic Disorder Due to AMC, or Substance-induced Psychotic Disorder

TIP:

**C60:** **Chronology of Brief Psychotic Disorder, Schizophreniform, Psychotic Disorder Due to AMC, Substance-Induced Psychotic Disorder, or Other Specified Psychotic Disorder – Age at Onset**

ASK: How old were you when you first had (psychotic sxs)?

RECORD age at onset of psychotic symptoms (code 99 if unknown)

**C61: SKIP instruction for AMC/Substance Causing Psychotic Symptoms**

CHECK here if symptoms not temporally associated with another medical condition, and go to \*SUBSTANCE INDUCED PSYCHOTIC DISORDER\* (page C.24)

**C62: Psychotic Disorder Due to Another Medical Condition – Criteria A**

CODE 3: If prominent hallucinations or delusions

TIP: Code based on information already obtained

**C63: Psychotic Disorder Due to Another Medical Condition – Criteria B/C**

CODE 3: If 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.

ASK: Did the (psychotic symptoms) change after (AMC) began? Did (psychotic symptoms) start or get much worse only after (AMC) began? How long after (AMC) began did (psychotic symptoms) change?

ASK (if AMC has resolved): Did the (psychotic symptoms) get better once the (AMC) got better?

TIP: The following factors should be considered and support the conclusion that AMC is etiologic to the depressive symptoms: (1) There is evidence from the literature of a well-established association between AMC and psychotic symptoms (2) There is a close temporal relationship between the course of the psychotic symptoms and the course of the general medical condition (3) The psychotic symptoms are characterized by unusual presenting features (e.g., late age-at-onset) (4) The absence of alternative explanations (e.g., psychotic symptoms as a psychological reaction to the AMC).

**C64: Psychotic Disorder Due to Another Medical Condition – Criteria E**

CODE 3: The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

If unclear, ASK: How much did (PSYCHOTIC SYMPTOMS) interfere with your life? (Has it made it hard for you to do your work, take care of your family, or be with your friends?)

If does not interfere with life: How much have the (PSYCHOTIC SYMPTOMS) bothered you?

**C65: Diagnosis of** **Psychotic Disorder Due to Another Medical Condition**

CODE 3: When Psychotic Disorder Due to AMC criteria A, B/C, and E are coded “3.”

TIP:

**C66:** **Specify if Diagnosis of** **Psychotic Disorder Due to Another Medical Condition is Current**

CHECK here, if current in past month

**C67:** **Psychotic Disorder Due to Another Medical Condition Specifications**

Specify if:

“With delusions” if the delusions are the predominant symptom

“With hallucinations” if the hallucinations are the predominant symptom

TIP:

**C68: SKIP instruction for Substance/Medication-Induced Psychotic Disorder**

If symptoms are not temporally associated with substance use, check here and return to disorder being evaluated (or else go to next module if skipped here from page c.1 because all psychotic symptoms in b were due to substance or AMC).

Disorders being evaluated: Schizophrenia (C. 5), Schizophreniform (C. 7), Schizoaffective (C. 10), Delusional (C. 12), Brief Psychotic (C. 16), Other Specified (C. 17)

**C69: Substance/Medication-Induced Psychotic Disorder Criteria A**

CODE 3: If there is a presence of one or both of the following symptoms: delusions or hallucinations

TIP: Code based on information already obtained

**C70: Substance Induced Psychotic Disorder (Check)**

CODE 3: If 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 substance/medication is capable of producing the symptoms in Criterion A

CODE 1: If not substance induced (and return to episode being evaluated, or next module if skipped here)

ASK (if not known): When did the (PSYCHOTIC SYMPTOMS) begin? Were you already using (substance/medication) or had you just stopped or cut down your use?

ASK (if not known): How much (substance/medication) were you using when you began to have (psychotic symptoms)?

TIP:

**C71: Rule-Out a Non-Substance Induced Etiology**

CODE 3: If the disturbance is NOT better accounted for by a Psychotic Disorder that is not substance-induced. Such evidence of an independent psychotic disorder could include the following: 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; or there is other evidence suggesting the existence of an independent non-substance/ medication-induced psychotic disorder (e.g., a history of recurrent non-substance/ medication-related episodes).

ASK (If unknown): Which came first, the (substance/medication use) or the (psychotic symptoms)?

ASK (If unknown): Have you had a period of time when you stopped using (substance/medication)?

ASK (if yes): After you stopped using (substance/medication), did the (psychotic symptoms) go away or get better?

ASK (if yes): How long did it take for them to get better? Did they go away within a month of stopping?

ASK (if unknown): Have you had any other episodes of (psychotic symptoms)?

ASK (if yes): How many? Were you using (substance/medication) at those times?

TIP:

**C72: Substance Induced Psychotic Disorder – Functioning**

CODE 3: If the symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

ASK (if unclear): How much did (psychotic symptoms) interfere with your life? Has it made it hard for you to do your work, take care of your family, or be with your friends?

If it does not interfere with life, ASK: How much have the (psychotic symptoms) bothered you?

TIP:

**C73: Substance/Medication Induced Psychotic Disorder Diagnosis**

CODE 3: If Substance-Induced Psychotic Disorder criteria A, B, C, and E are coded “3”

NOTE: The D criterion (Delirium r/o) has been omitted

TIP:

**C74:** **Substance/Medication Induced Psychotic Disorder Diagnosis – Current**

CHECK here if current in past month

**C75: Context of Development of Mood Symptoms in** **Substance- Induced Psychotic Disorder**

INDICATE context of development of mood symptoms:

1 – With Onset During Intoxication

2 – With Onset During Withdrawal