**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?