The SCID

for DSM-5
Basic Overview of the SCID

Possible Uses (nonexhaustive list)

- Systematically evaluate (nearly) all DSM diagnoses
- Select a population for study (inclusion, exclusion)
- Characterize a study population (current, past hx)
- Improve interviewing skills of students in mental health professions
Basic Overview of the SCID

Versions

Clinical Version (CV)
- Streamlined, limited specifiers covered
- Limited disorders covered
  - Screening questions for others
  - Missing many important disorders
- Focus on current, not lifetime disorder (except MDD, BP-I/II, Schizophrenia Spectrum Disorders, Panic Disorder, PTSD)

Research Version (RV)
- Covers more disorders and specifiers than CV
- Core plus optional modules
- Published in e-format so researcher can tailor

Clinical Trials (CT)
- Streamlined version of RV for typical clinical trial screening
Disorders only screened for in SCID-CV

- Premenstrual Dysphoric Disorder
- Specific Phobia
- Separation Anxiety Disorder
- Hoarding Disorder
- Body Dysmorphic Disorder
- Tichotillomania (Hair-pulling Disorder)
- Excoriation (Skin-picking Disorder)
- Insomnia Disorder
- Hypersomnolence Disorder

- Anorexia Nervosa
- Bulimia Nervosa
- Bing-eating Disorder
- Avoidant/Restrictive Food Intake Disorder
- Somatic Symptom Disorder
- Illness Anxiety Disorder
- Intermittent Explosive Disorder
- Gambling Disorder

Note: Only one question on each of these disorders!
Basic Features of SCID

- Suitable for anyone with 8th grade education
- Takes 45-120 Minutes (Your results may vary)
- Inclusion of an Open-Ended Overview
  - Present Illness
  - Treatment history
  - Substance use treatment history; current use
  - Medical conditions/issues
  - Suicidal thoughts/behavior
  - Should gather enough info to formulate *tentative* differential diagnosis to be fleshed out with the various modules of the SCID

- Use overview to establish rapport, explain purpose, gather information
- Flow of interview is designed to approximate an experienced clinician
A few details (part 1)

- Ratings are of Criterion Items, *not* of answers to questions per se
  - Simple "Yes" not sufficient -- elaboration
  - Sometimes extra-interview info is required -- rating will reflect all available sources of information!
- An item can be coded as present even in the face of a denial by the patient
- If clinician doubts the presence of a symptom that a patient insists is present, rate it as not present.
A few details (part 2)

- Mandatory questions
  - Depending on answer, follow-up questions
  - And you almost always need to ask *more* questions

- Diagnostic summary sheet
  - Should be completed by end of interview
    - Can try concurrently (if you are a wizard)
    - Or markup a copy of the interview and then transfer the information
“Do’s” and “Don’ts”

- **Do** use the Overview to obtain the patient’s perception of the problem and treatment history.

- **Don’t** ask questions in the Overview for details of specific symptoms (as those are covered later).

- **Do** stick to the initial questions as they are written, except for minor modifications to consider what the patient has already said.

- **Don’t** make up your own initial questions because you feel that you have a better way of getting the same information.

- **Do** ask additional clarifying questions to elicit details in the patient’s own words.
“Do’s” and “Don’ts”

- DON’T use the interview as a checklist or true/false test
- DO use your judgment about a symptom, considering all of the information available, and confront the patient (gently of course) about responses that conflict with other information
- DON’T automatically accept a patient’s response if it contradicts other info or if you believe it is not valid
- DO make sure the patient understands what you are asking; repeat or rephrase if needed; describe entire syndrome if needed (e.g., manic episode)
- DON’T use words or jargon the patient does not understand
“Do’s” and “Don’ts”

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

- **DON’T** assume the symptoms a patient is describing cluster together in time unless you have clarified the time period for each question.

- **DO** focus on getting enough information to evaluate each DSM criterion, which will require asking follow-up questions.

- **DON’T** focus on simply getting an answer to the questions (Two columns, evaluate the second, the criteria!)
“Do’s” and “Don’ts”

- **DO** give the patient the benefit of the doubt about a questionable psychotic symptom by rating “-” (absent)
- **DON’T** call a subculturally accepted religious belief or an overvalued idea a delusion.
- **DO** be careful with rule-outs: If it is TRUE that an episode is not better accounted for by the physiological effects of a substance, then mark “YES”
- **DON’T** skip a section without completing it because you feel sure it does not apply (e.g., psychotic symptoms in a college student)
Use open-ended questions whenever possible!

- What, how, in what way
- NOT: Did, is, was…
- By example:
  - *What was that like?* (Were you sad?)
  - *How did that affect your ability to do things?* (Did that interfere with your work, school, social life?)
  - *How long did that last?* (Did that last at least 2 weeks?)
  - *What kinds of thoughts did you have at that time?* (Did you feel worthless?)
- And you can always say: *Tell me more about that*…