INSTRUCTION MANUAL

For The

Standard for Clinicians' Interview in Psychiatry (SCIP)

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Introduction

The Standard for Clinicians' Interview in Psychiatry (SCIP) is a method of assessment of psychopathology, administered by psychiatrists or clinicians with extensive experience and knowledge about mental health and the diagnostic criteria for mental disorders. Although several structured and semi-structured interviews exist in the psychiatric literature (1-4), none of them is designed to be used by psychiatrists in the real world of psychiatric practice (5, 6). To remedy this serious gap, Dr. Aboraya has developed the Standard for Clinicians' Interview in Psychiatry (SCIP), the only instrument designed explicitly to meet psychiatrists' needs in real clinical practice, whether inpatient or outpatient (7-20). The SCIP symptoms, signs, dimensions and diagnoses were tested in an international multisite study in three countries (USA, Canada and Egypt) between 2000 and 2012 and have been shown to be reliable and valid (21, 22). The total sample size, including all sites, was 1,004 subjects, making the SCIP project the largest validity and reliability study of a diagnostic interview in psychiatry.

The SCIP is an exemplary reference guide for psychiatric assessment and includes the SCIP interview and the SCIP manual. Clinicians develop their own style of interviewing, shaped by mentors, experience and other various factors, and no tool can change that. As clinicians follow the SCIP method of psychiatric assessment, they can

use the SCIP questions (which have been shown to be reliable) and follow the SCIP rules of rating symptoms and signs. Clinicians use the patient's responses to questions, observe the patient's behavior and utilize proxy information such as chart review to make the final rating on the presence or absence of psychopathological symptoms and signs. It is the clinician's judgment, not the patient's responses, that prevails.

The SCIP method of psychiatric assessment has three components: the SCIP interview (dimensional) component, the etiological component and the disorders classification component. The SCIP yields three types of output: a diagnostic classification of the disorder, dimensional scores and numeric data. The SCIP provides diagnoses according to the Diagnostic and Statistical Manual (DSM) and International Classification of Disease (ICD) criteria. A dimensional score is provided for the following types of psychopathology: anxiety, posttraumatic stress, obsessions, compulsions, depression, mania, suicidal behavior, self-injurious behavior, delusions, hallucinations, agitation, disorganized behavior, negative symptoms, catatonia, alcohol addiction, drug addiction, attention and hyperactivity. The SCIP produces numeric data for psychopathological symptoms and signs that can be used for research.

SCIP Advantages

1. The SCIP interview takes the same amount of time as a typical psychiatric diagnostic interview (25-40 minutes), allows clinicians to maintain therapeutic rapport with patients and does not require training.

2. The SCIP is flexible and allows clinicians the freedom to administer the interview as they see fit. The SCIP interview starts with the Screening Section followed by the

Modular Section. The SCIP Screening Section has questions on anxiety, mood, psychosis, alcohol and substance, somatoform, eating, attention and hyperactivity. The clinician can start with any question that he/she finds most appropriate. The clinician decides on the episode period to evaluate. After the Screening Section, the clinician chooses the module(s) to make the appropriate diagnosis (es). If the clinician decides to explore two or more modules, he/she can start with any module as deemed appropriate. No other structured or semi-structured interview currently available allows such freedom for the clinician, simply because the SCIP utilizes the full extent of clinicians' expertise in conducting diagnostic interviews. No structured or semi-structured interview can ever replace clinicians' skills.

3. The SCIP is the only instrument designed to produce three types of output: numeric data for symptoms/signs and their severity, dimensional scores for clusters of symptoms (anxiety, posttraumatic stress, obsessions, compulsions, depression, mania, suicidal behavior, self-injurious behavior, delusions, hallucinations, agitation, disorganized behavior, negative symptoms, catatonia, alcohol addiction, drug addiction, attention and hyperactivity) and disorder categories according to the to the Diagnostic and Statistical Manual (DSM) and International Classification of Disease (ICD) criteria.

4. The building blocks of the SCIP are the symptoms and signs of psychopathology that do not change with time. Whether we have the ICD-10 or beyond, DSM-5 or beyond, the phenomenology of mental disorders remains unchanged and the SCIP will withstand future diagnostic criteria changes. For example, although the SCIP was developed and tested before the DSM-5 publication in 2013, the SCIP contains the main criteria needed to make the diagnosis of the new DSM-5 disruptive mood dysregulation disorder

(irritable mood, verbal and physical aggression, manic and hypomanic episode). The clinician inquires about the frequency, duration and onset of temper outbursts and decides whether or not the patient meets the criteria for the diagnosis of disruptive mood dysregulation disorder.

5. The SCIP is the only instrument that transforms routine clinical information into data that can be used for research. Psychiatrists evaluate thousands of patients daily. The multitudes of records produced daily, such as psychiatric evaluations and progress notes, have mainly one primary use: clinical management, as well as several secondary uses: billing, legal issues and research. The SCIP retains the clinical management function and also produces data that can be gleaned for research. If all psychiatric interviews were transformed into research data, the potential value for scientific inquiry would be significant.

The SCIP Approach to Psychiatric Diagnosis: "Bottom First Then Top (BFTT)" Approach

Two approaches to psychiatric diagnosis have been described in literature: the "top-down" approach and the "bottom-up" approach (2, 4, 23-25). In the top-down approach, exemplified by the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I), questions are grouped by diagnosis and criteria; within each diagnosis, if a required criterion is not met, the interviewer skips the remaining questions assessing the other criteria for that diagnosis. For example, if the patient denies depressed mood and anhedonia, the SCID-I instructs the interviewer to skip the remaining questions for the diagnosis of major depression (2). The top-down approach leads to efficient interviews by focusing on diagnoses, facilitates clinical communication and improves reliability. On the other hand, diagnostic interviews based upon top-down approach are biased toward preconceived diagnostic criteria, lack validity, may result in the loss of important information and need to be updated every time the diagnostic system changes. With the publications of DSM-5 in May 2013, the SCID-I requires major changes to be compatible with the new DSM-5 version. Using the bottom-up approach, as exemplified by Schedules for Clinical Assessment in Neuropsychiatry (SCAN), the interview is based upon comprehensive assessment of symptoms without consideration of possible diagnoses (4). After symptoms assessment, algorithms are used to make psychiatric diagnoses. The bottom-up approach has the advantages of avoiding biases toward preconceived diagnoses and can survive diagnostic criteria changes. However, bottom-up approach leads

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to lengthy interviews and may lack the precision needed to fulfill diagnostic criteria (25).

The SCIP method to psychiatric diagnoses is better described as **"Bottom First Then Top (BFTT)" approach.** An ideal diagnostic psychiatric interview starts with a bottom-up approach: the psychiatrist establishes rapport with the patient and inquires about chief complaint(s) and history of the present illness. The patient is allowed to take the lead first and express feelings, thoughts, current stressors and other problems. The psychiatrist continues the bottom-up approach by obtaining a detailed life history, screening for symptoms, examining mental status, exploring potential causes of symptoms and utilizing records and informants as needed. As the psychiatrist narrows down the potential diagnoses, the top-down approach takes over. The psychiatrist checks the symptoms and decides whether or not the patient meets the diagnostic criteria of a disorder. The SCIP reflects the BFTT approach of psychiatric assessment through its three components: the SCIP interview component and the etiological component are both mainly bottom-up approaches, and the disorders classification component is mainly a top-down approach.

The BFTT approach avoids biases toward preconceived diagnoses by starting with comprehensive symptoms assessment. For example, during the screening part of questioning, the patient may deny depressed mood, anhedonia, euphoric mood, irritable mood, labile mood or any mood swings. However, the interviewer may observe and collect collateral data to indicate mood problems (e.g. pressured speech, impulsive behavior or past suicidal attempts). In this case,

the interviewer proceeds to the mood module and explores manic and depressive

symptoms and signs. The SCIP is an efficient interview because it utilizes the

clinicians' skills and expertise to guide to valid diagnoses. For example, during

the first five minutes of an interview, the patient explained to the psychiatrist with

conviction that he was born on Mars and brought to earth by aliens on a

spaceship. The patient was waiting in the hospital to be rescued and to go back to

where he belongs: Mars. The patient was clearly responding to internal stimuli

and a quick review of his history indicated multiple psychiatric admissions for

similar circumstances. The psychiatrist explored module C and the patient met

the diagnostic criteria for schizophrenia. The SCIP relies on the algorithm of the

human mind (clinician's expertise and knowledge) to conduct efficient interviews.

No paper or computer algorithms can match the algorithm of the human mind.

Seasoned, competent psychiatrists have actually used the BFTT approach for

decades, even though the term BFTT was coined first in the SCIP reliability paper

(21). Michael B. First's recent "DSM-5 Handbook of Differential Diagnosis,"

describing 29 bottom-up decisions trees leading to diagnoses based upon DSM-5

criteria, actually follows a BFTT approach (26). ***The motto of the BFTT***

approach is to understand the patient first, then make a diagnosis.

The SCIP Method of Psychiatric Assessment

The SCIP method of psychiatric assessment reflects a typical psychiatric evaluation conducted by psychiatrists and clinicians in different settings (inpatient, outpatient or day hospital) and has three components: the SCIP interview, the etiological search and the disorders classification.

A. The SCIP interview (dimensional component): This is the psychiatric interview with the patient and has three phases. See the SCIP interview and Appendix I for instruction on rating the responses to the SCIP questions.

B. Etiological search (etiological component): As the clinician conducts the interview, he/she explores the potential causes of symptoms. If the patient has depression and drinks alcohol, the clinician explores whether depressed mood is secondary to alcohol or whether the patient has a dual diagnosis (e.g. alcohol use disorder and major depression). As medical conditions affect psychiatric presentations, a psychiatrist uses medical knowledge and clinical skills to decide whether any medical conditions might have caused or exacerbated psychiatric symptoms. For a mental health professional who lacks medical training (such as a psychologist or a clinical social worker), he/she can consult with medical personnel if medical conditions are affecting psychiatric presentations and vice versa. See Appendix II outlining causal specifiers and Appendix III for certainty of causal specifiers.

C. Disorders classification (categorical component): The clinician evaluates whether the symptom or cluster of symptoms causes significant distress (see Appendix IV) or functional impairment (see Appendix V). Finally, the clinician utilizes all of the

information available to decide whether the patient meets the criteria for a psychiatric

disorder(s) based on the DSM or ICD criteria.

<center>**A. The SCIP INTERVIEW**</center>

<center>**(DIMENSIONAL COMPONENT)**</center>

I: Phases of Psychiatric Interview: The SCIP interview reflects the type of psychiatric interview typically conducted by psychiatrists and clinicians and has three phases.

Phase one (5-10 minutes): The clinician greets the patient, introduces himself/herself and asks the patient basic demographic questions (age, marital status, education, occupation and living arrangements). The clinician asks about the chief complaint(s) and allows the patient to take the lead by describing the history of the present illness and any recent stressor(s). The clinician observes and listens to the patient, allowing for good rapport to be established, and may write brief notes. When a symptom is absent, it is left blank in the paper version of the SCIP interview. Similarly, in the computer version of the SCIP, the default rating is zero. This way, the clinician gives most of his/her attention to the patient in order to maintain good rapport.

Phase two (10-15 minutes): At the beginning of this phase, the clinician should have a good idea about the main problem(s) of the patient. The clinician takes the lead and asks screening questions covering the main domains of psychopathology. The SCIP has screening questions on anxiety, mood, psychosis, alcohol, drugs, somatoform, eating, attention and hyperactivity. There is no specific order for the screening questions. The clinician may choose the order of questions that allows the interview to flow smoothly and maintains a good rapport with the patient. For example, if the patient's main symptom is depressed mood, it is wise to start with the moods questions and inquire more about anhedonia, elevated mood and mood swings. Then the clinician can screen for anxiety and psychosis. Another example: if the patient's main problem is alcohol or drug

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use, it is wise to start with the alcohol and drug questions and get relevant information as to the extent of the substance use problem. The clinician inquires about a time when the patient was sober for a reasonable amount of time and screens for anxiety, mood and psychosis during the time of sobriety. Another example: if the patient appears from the onset to be psychotic, disorganized and responding to internal stimuli, the clinician may proceed with module C (Schizophrenia and Psychosis). For this patient, the clinician may skip anxiety and somatoform questions because the patient is too disorganized to provide any valid information. In summary, there are no rules or specific order to be followed in this phase. The clinician utilizes his/her clinical skills, aided by the SCIP screening questions, to detect any abnormal psychopathology. It is important to remember that the SCIP screening questions represent a review of the main psychopathological domains of adults. It is also important for the clinician not to miss any important areas of psychopathology in this phase. Finally, symptoms found to be present during this screening phase can be used for diagnosis of psychiatric disorders.

Phase three (10-15 minutes): By this phase of the interview, the clinician should have determined potential diagnostic possibilities. The clinician decides which module(s) to use and explores the specific symptoms of the disorder(s) in detail. Depending on the patient, the clinician may explore one or several modules. The SCIP has the following modules: Module A: Anxiety, Panic and Posttraumatic Stress Disorders, Module B: Mood Disorders, Module C: Psychotic Disorders, Module D: Alcohol and Substance-Use Disorders, Module E: Somatoform Disorders, Module F: Eating Disorders, Module G: Attention Deficit Disorders, Module H: Adjustment Disorders, Module J: Memory Disorders and Module P: Personality Disorders.

During this phase, the clinician determines whether the symptoms cause significant distress or impairment of function. Finally, the clinician determines whether the patient does or does not have a psychiatric disorder(s) and initiates treatment planning.

It is important to know that sequence of the three phases described above does not have to be followed in that order. Many psychiatrists like to start with asking patients about the chief complaint(s) and history of present illness at the beginning of the interview and the demographic information comes later as the interview proceeds. Many psychiatrists do phases two and three together. For example, if the patient describes depressed mood, the interviewer follows up by asking about depressive symptoms (anhedonia, hopelessness, suicidal thoughts and plans, etc.). Similarly, if the patient reports abuse, the interviewer asks about posttraumatic stress symptoms (bad dreams, nightmares, flashbacks, etc.). The technique of doing phases two and three simultaneously makes the interview proceeds smoothly with a natural progression and helps to maintain good rapport with the patient. Finally, the interviewer is free to perform the interview as he/she prefers.

II: The SCIP Interview has four main sections in this sequence:

1. Demographic, Social and History of Present Illness Section.

2. Screening Section.

3. Medical, Family and Psychiatric History Section.

4. SCIP Modules Section.

III: Rating of Responses to Questions:

1. *Episodes:*

Questions are asked regarding a specific period (past week, past month, past year, etc.).

The interviewer decides on the specific time frame for the questions and modules. The

interviewer may choose the past month when evaluating mood, the past year when

evaluating alcohol and so on.

2. *Principles of coding psychiatric symptoms and signs:*

The general principle is to code 0 for absent or subclinical symptoms. Clinical symptoms

are coded 1 or 2 or 3.

Many questions have the following codes:

0   =   Absent or non-significant.

1   =   A symptom is present less than 50% of the time or less than 50% of times.

        The mere presence of a symptom does not qualify for a rating of one. To receive a rating of one, a symptom must be more than what a normal person would experience, or cause at least some distress, or force the patient to seek professional help.

2   =   The same as a rating of one. In addition, the symptom is present more than 50% of the time or more than 50% of times.

9   =   Missed question, the patient refused to answer the question or the interviewer was unsure.

Example: Hopelessness	Kappa
Have you felt hopeless about your future? 0 Patient has no feelings of hopelessness. 1 Patient feels hopeless less than half the time. 2 Patient feels hopeless more than half the time.	0.82

Many questions have ratings of 0 (absent or subclinical symptom) and 1 (clinical

symptoms).

Example: PANIC ATTACKS WITHOUT PHOBIA	kappa
Have you gotten suddenly anxious and frightened for a short period of time (up to 60 minutes)? **During that time, did you feel that your heart was racing or pounding, or did you start shaking or sweating, or did you feel you were choking?** 0 Patient had no panic attacks. 1 Patient had panic attacks.	0.92

Several questions have possible responses of 0 (absent or subclinical), 1, 2 and 3 to allow

for severity measurement and to generate a valid dimensional score when added to

responses from other questions.

Example: Frequency of auditory hallucinations	kappa
How often do you hear any noises (like music, whispering sounds) or voices talking to you when there is no one around? 0 No auditory hallucination 1 1-4 days / month 2 5-14 days / month 3 15-30 days / month	0.93

3. Symptoms of psychopathology:

As in case of medicine, modern psychiatric diagnosis depends on the assessment of psychopathological symptoms and signs. The SCIP interview reflects a state-of-the-art approach to assessment and includes questions designed to evaluate symptoms and observational items for the signs of mental illness. The SCIP questions were designed with four principles:

a. Questions are worded to be simple and easily understood by patients regardless of their intellectual level.

b. Questions simulate what seasoned psychiatrists usually ask.

c. The meaning of the questions and examples are embedded in the questions so that each question and the response reflect the criterion being examined.

d. Questions' responses have the least subcategories and reflect the clinical significance of the symptom. The fewer the subcategories reflecting symptom severity, the more efficient the interview, and the more likely that clinicians will use the questions.

For example, one of the criteria for a major depressive episode is "diminished ability to think or concentrate." Here is the SCIP question and possible responses:

Example: Loss of concentration	kappa

Have you found that your concentration has decreased and you are unable to complete a task (e.g. at work, reading an article, reading a book, or watching a movie), even though you were able to do that before?
 	
      0   Patient has no concentration problems.
      1   Patient has difficulty concentrating less than half the time.
      2   Patient has difficulty concentrating more than half the time.
	0.80

The question and responses explain the criterion, give examples of impaired

concentration and measure the severity (less than half the time or more than half the

time).

4. Signs of psychopathology:

The SCIP interview includes observational items to assess for the signs of mental illness.

The interviewer listens to the patient, asks him/her questions, examines the patient and

rates the observational items.

Some observational items have questions. For example, the interviewer observes the

patient's speech and can ask about pressured speech over a specific period of time.

Example: Pressured speech	kappa

Have you been talking faster than usual during that time (examples: people said that they were unable to understand you because you were speaking too fast or you felt a pressure to continue talking)?
    0   Patient has normal speech.
    1   Patient has pressured speech less than half the time.
    2   Patient has pressured speech more than half the time.
	0.72

Some observational items need examination by the interviewer, as in catatonia. The

interviewer observes the patient, tests for mobility, rigidity, catalepsy and waxy

flexibility, and rates catatonia items.

Catalepsy: Patients maintain any odd or unusual posture the interviewer places them in.

    0   Patient has no catalepsy.
    1   Patient has catalepsy.

Waxy flexibility: Patient maintains a limb in a certain position. When the interviewer moves the limb, the limb feels as if it were made of wax.

    0   Patient has no waxy flexibility.

    1   Patient has waxy flexibility.

Some observational items are described and observed.

Flight of Ideas (a combination of pressured speech and derailment):	kappa
0 Patient has no flight of ideas. 1 Patient has flight of ideas.	0.62

Apparent hallucinatory experiences:	Kappa
0 Patient has not been observed talking to self. 1 Patient has been observed talking to self, talking to a mirror, or running a conversation with unseen person.	0.55

DISORGANIZED THOUGHTS

    1   Patient has derailment (looseness of association): speech shifts to different topics, related or unrelated, but eventually comes back to the main topic.

    2   Patient has severe derailment (severe looseness of association): speech shifts to different topics, mostly unrelated and never comes back to main topic.

    3   Patient has flight of ideas: a combination of pressured speech and derailment.

    4   Patient has tangentiality: replying to a question is related in some distant way or totally unrelated.

    5   Patient has incoherent speech: first sentence is unrelated to the next sentence. Each sentence on its own makes sense.

    6   Patient has word salad speech: incoherence of speech at the level of the sentence, that is, the first word has nothing to do with the second word.

    7   Patient has illogical speech: conclusion of speech is not logical.

8   Patient uses neologisms.

5. General Notes on Ratings:

    a. **Do not over-rate symptoms. If the symptom is present and the clinician is not sure whether to rate 1 or 2, the code should be 1. If the clinician asks and decides the patient has concentration problem but he/she forgot to ask about the duration, the code should be 1 and not 2.**

    b. **A symptom rated 1 will qualify for diagnostic criteria.**

    c. **If the clinician is not sure whether the symptom is present after a thorough questioning, the clinician can make a judgment call about whether the symptom is present or absent. If the clinician does not feel comfortable making a decision, he/she can choose the rating of 9. A written explanation by the clinician is advised in these cases.**

6. Special Notes on Delusions:

Delusions are ideas that have the following criteria:

    a. The idea is false based on what most people of the same culture know (false idea).

    b. The patient is convinced that the idea is true (firm idea).

    c. If the patient is provided with evidence that contradicts the idea, the patient is still convinced that the idea is true (fixed idea).

If the patient has paranoid delusions less than half the time, the rating is one. If the patient has paranoid delusions more than half the time, the rating is two. Typically, a patient with delusions goes through three phases:

a. Initial partial delusions: This is the transition from normal thoughts to delusional thoughts. The delusional thoughts gradually occupy some of the patient's time. As time goes on and the patient receives no treatment, the delusional thoughts occupy more of the patient's time.

b. Full delusions: This is when the delusions occupy most or the entirety of a patient's time. Typically, when patients are admitted to hospitals, they have full delusions.

c. Residual partial delusions: As the patient receives antipsychotic medications and improves, the patient starts to question his/her delusional thoughts. The delusional thoughts occupy less and less of the patient's time. Eventually, the delusional thoughts disappear.

The SCIP Principles of Creating Reliable Psychological Dimensions

The SCIP study measured Kappa for 150 psychological symptoms and signs including 28 SCIP screening questions. Ninety six percent of the SCIP items had fair to good reliability (Kappa => 0.5). Based upon reliable SCIP items, the SCIP dimensions were created. The SCIP questions were designed so that dimensional measures can be generated easily whether the interviewer is using the paper version or the SCIP software. *The SCIP method of creating reliable and clinically relevant dimensions was based upon the following 9 principles:*

1. **Reliable dimensions require reliable symptoms and signs.** Psychological symptoms and signs are the building blocks of psychological dimensions. The SCIP study confirmed the hypothesis that reliable psychological dimensions require reliable symptoms and signs. The absence of valid and reliable symptoms was the main limiting factor in creating dimensional measures in the past (27). The SCIP reliable symptoms and signs removed this major obstacle. Based upon reliable SCIP items, the SCIP dimensions were created and have shown to be reliable (21).

2. **Each item is given one score, regardless of the number of questions exploring the item.** Typically, a SCIP item is assessed with one question. The question has embedded examples, if needed, so that each question and the response reflect the criterion being examined. Sometimes, one criterion needs to be assessed using several questions. In that case, even if the patient responds yes to several questions evaluating the criterion, the score is the same as if the criterion were measured with one question.

For example, the symptom of suicidal ideations can be assessed by the following eight questions:

Have you had thoughts of suicide?
Have you had thoughts of ending your life?
Have you had thoughts about killing yourself?
Have you had thoughts of wishing to be dead?
Have you had thoughts that life is not worth living?
Have you had thoughts that you would not care if you didn't wake
in the morning?
Have you had thoughts the world is better off without you?
Have you had thoughts you would be better off dead?

If the patient responds yes to the first four questions, these questions still only

reflect one criterion: suicidal ideation.

3. **Dimensions are built upon significant symptoms and signs.** Absent or mild

   symptoms are coded "0" in the SCIP.

4. **The principle of least subcategories of symptom severity (LSSS):** Symptom

   severity subcategories should be used sparingly and reflect the symptom's clinical

   significance. The symptom of panic attacks can be assessed as absent or present

   (0, 1). The symptom of poor concentration in a patient with depression can be

   assessed as absent, less than half the time and more than half the time (0, 1, 2). It

   is important to know how much of the time the concentration problem is present

   because it may affect the patient's functioning at work or in school. The fewer

   the subcategories reflecting symptom severity, the more efficient the interview,

   and the more likely that clinicians will use the questions. If there are too many

   unnecessary subcategories of symptoms severity, reliable and clinically useful

   dimensions cannot be created. For example, the Positive and Negative Syndrome

   Scale (PANSS) has seven subcategories: absent, minimal, mild, moderate,

moderate severe, severe and extreme (28). For clinicians, the differences between minimal and mild, moderate and moderate severe, severe and extreme are not useful or relevant. Not surprisingly, psychiatrists do not use the PANSS in clinical settings (29).

5. **The frequency of symptoms:** The more frequent the symptom, the higher the score on the item. A good example is the frequency of auditory hallucinations:

> **How often do you hear noises (like music, whispering sounds) or voices talking to you when there is no one around?**
>
> 0   Patient has no auditory hallucinations.
> 1   Patient has auditory hallucinations (1-4 days / month).
> 2   Patient has auditory hallucinations (5-14 days / month).
> 3   Patient has auditory hallucinations (15-30 days / month).

6. **The duration of symptoms:** The longer the duration of a symptom, the higher the score on the item.

> **Do you have an intrusive thought or image that does not make sense and keeps coming back to your mind even when you try not to have the thought or the image?**
>
> 0   Patient has no obsessions.
> 1   Patient has obsessions less than 1 hour/day.
> 2   Patient has obsessions 1-4 hours/day.
> 3   Patient has obsessions more than 4 hours/day.

7. **The recency of a symptom:** More recent behavior has a higher score than distant behavior. For example, in response to the timing of suicidal ideation question:

Have you ever had thoughts of suicide?

0   Patient has never had suicidal ideation.
1   Patient had suicidal ideation in past, but not in the past three months.
2   Patient had suicidal ideation during the past three months (excluding past week).
3   Patient had suicidal ideation during the past week.

Suicidal thoughts during the past week receive a score of 3, past three months receive a score of 2, and if the patient has had suicidal thoughts before the past three months, this receives a score of 1. A patient with suicidal thoughts during the past week, past 3 months and past year receives a score of 6.

8. **The quality of symptoms:** Certain qualities of some symptoms increase the score on the item. For example, auditory hallucination with and without commands.

   Do you hear noises (like music, whispering sounds) or voices talking to you when there is no one around?

            0   Patient has no auditory hallucinations.
            1   Patient has auditory hallucinations.
            2   Patient has auditory hallucinations with command.

9. **Summation Principle:** The total score of a dimension is the summation of symptom presence, recency, frequency, duration and quality.

APPENDIX I

Rating Responses to SCIP questions

Unless otherwise specified in the question, the rating of a symptom is as follows:

CODES:

0 = Absent or non-significant

1 = Symptom present < 50% of the time or <50% of times

2 = Symptom present > 50% of the time or >50% of times

A positive rating of 1 implies that the patient has the symptom more than most

people, or has at least some distress or seeks professional help.

9=missing data, or unsure <u>unless otherwise specified in the question.</u>

Many questions have the rating of 0 or 1 as follows:

CODES:

0 = Absent or non-significant

1 = Symptom present

A positive rating of 1 implies that the patient has the symptom more than most

people, or has at least some distress or seeks professional help.

9=missing data, or unsure <u>unless otherwise specified in the question.</u>

B. ETIOLOGICAL ASSESSMENT

(ETIOLOGICAL COMPONENT)

The psychiatrist explores potential causes of psychopathology and uses medical knowledge and clinical skills to decide if any specific medical condition has caused or exacerbated psychiatric symptoms. The SCIP method of psychiatric assessment does not exclude any particular school of thought. A clinician is welcome to use any theory or theories to elucidate the causes of mental disorders, as long as the clinician has scientific data to support those theories. Appendix II (causal specifiers of mental disorders) covers a wide range of factors that may cause or contribute to manifestations of mental disorders. Causal specifiers include definite etiopathies and factors contributing to the manifestation of the mental disorder (contributing factors) (30, 31).

Definite Etiopathy (DE): Definite etiopathy is a factor that is determined to be the cause of a mental disorder. For example, a 45-year-old lawyer with no psychiatric problems sustains a head trauma in a car accident. The MRI after the car accident shows a subdural hematoma. A mental status evaluation and neuropsychological testing show significant memory deficits. The final diagnosis is amnestic disorder due to head trauma. The head trauma or the subsequent subdural hematoma is a definite etiopathy (DE) in this case. ***Remember, definite etiopathies are rare in medicine and psychiatry.*** Most of the causal specifiers are Factors Contributing to Manifestations of Mental Disorders (FCM_MD). These contributing factors (biological, environmental, social, developmental or others) play a part in contributing to the manifestations of the illness, but they stop short of being definite etiopathies. These contributing factors are very important in case formulation, differential diagnosis and treatment decisions. As our

understanding of these contributing factors improves, some contributing factors may be

upgraded to definite etiopathies.

APPENDIX II

CAUSAL SPECIFIERS

OF

MENTAL DISORDERS

A. *Biological*

1. Drug abuse   _1A: Alcohol

                        _1B: Illicit drugs (e.g. THC, cocaine…etc.)

                        _1C: Toxins (e.g. heavy metals)

2. Effects of prescribed medications (e.g. antidepressants, neuroleptics)

3. Effects of somatic treatment (e.g. ECT)

4. Discontinuing psychotropic medications

5. Biological Diseases   _5A: Cerebral diseases:

                                        1. Trauma

                                        2. Infection (e.g. HIV, meningitis,

                                            cerebritis)

                                        3. Tumors

                                        4. Vascular (e.g. stroke)

                                        5. Seizure

                                        6. Hereditary (e.g. Huntington's

                                            disease)

7. Age related (e.g. dementia)

8. Brain imaging changes

9. Neurological diseases

10. Others

_5B: Systematic diseases:

1. Trauma

2. Infections

3. Tumors

4. Cardiovascular diseases

5. Hematologic diseases

6. Respiratory diseases

7. Nutritional diseases

8. Autoimmune disease

   (e.g. SLE)

9. Endocrine diseases

10. Encephalopathies (e.g.

    hepatic)

11. Gastrointestinal diseases

12. Renal diseases

13. Hypoxia

14. Electrolytes imbalances

15. Metabolic disease

16. Others

_5C: Specific conditions:　　　1. Peri-menstrual

　　　　　　　　　　　　　　　　　　　　　　　　2. Postpartum

　　　　　　　　　　　　　　　　　　　　　　　　3. Peri-menopausal

　　　　　　　　　　　　　　　　　　　　　　　　4. Others

6. Other biological factors

B. Genetic/familial Profile

C. Neuroscience Profile

1. Neurobiological profile

2. Neurotransmitters profile

3. Molecular biology profile

4. Biomarkers

5. Others

D. Environmental

1. Life events (e.g. death of a parent when the child was very young)

2. Adverse events in childhood　　　_2A: poverty

　　　　　　　　　　　　　　　　　_2B: neglect of a child

　　　　　　　　　　　　　　　　　_2C: removal of a child from home

　　　　　　　　　　　　　　　　　_2D: migration

　　　　　　　　　　　　　　　　　_2E: other

3. Childhood abuse　　_3A: Emotional

　　　　　　　　　　　_3B: Physical

_3C: Sexual

4. Traumatic events (catastrophes, wars…etc.)

5. Other environmental factors

E. Developmental

1. Developmental milestones (age of walking and talking, puberty changes).

2. Developmental problems: 2_A. Mental retardation

                                      2_B. Learning disabilities

                                      2_C. Others

3. History of serious illnesses in childhood

4. Family factors

5. Religious upbringing

6. Cultural factors

7. Other developmental factors

F. Social

1. Relationship factors   _1A: Marriage

                                      _1B: Separation

                                        _1C: Divorce

                                        _1D: Children

                                        _1E: Problem with significant other

                                        _1F: Living alone

                                        _1G: Others

2. Change in support system   _2A: Family

_2B: Friends

                        _2C: Doctors, therapists

                        _2D: Others

3. Social stressors   _3A;   Jobs: 1. unemployment

                                             2. underemployment

                                             3. stressful work

                                             4. stressful schedule

                                             5. job change

                                             6. discord with boss or co-workers

                        _3B: Financial

                        _3C: Educational: 1. illiteracy

                                               2. problems in school

                                               3. discord with teachers or

                                               classmates

                                               4. other problems

                        _3D: Housing: 1. homeless

                                            2. inadequate housing

                                            3. moving to a new area

                                            4. unsafe neighborhood

                                            5. discord with neighbors

                                            6. other

                        _3E: Physical illness of the patient, family

                               member or others

_3F: Death of family members or friends

_3G: Access to health care services:

        1. no health insurance

        2. inadequate health insurance

        3. transportation problem

_3H: Others

4. Legal

5. Other social factors

G. Psychodynamic factors

H. Behavioral factors

I. Cognitive factors

J. Personality characteristics factors

K. Other Categories

Appendix III

Degree of Certainty of Causal Specifiers

0:      No cause

1:       Some evidence exists: Factors Contributing to Manifestations of Mental Disorders

       (FCM_MD)

2:       Strong evidence exists: Definite Etiopathy (DE)

C. DISORDERS CLASSIFICATION

(CATEGORICAL COMPONENT)

The clinician decides whether the symptom or cluster of symptoms causes significant distress (Appendix IV) or impairment of function (Appendix V). Finally, the clinician decides whether the patient meets the criteria for a psychiatric disorder(s) based on the DSM or ICD criteria.

APPENDIX IV

(DISTRESS EVALUATION)

A symptom or a cluster of symptoms can cause distress to the patient as follows:

CODES:

0 = No distress

1 = Some distress, but manageable

2 = Significant distress: the patient is distressed, upset or bothered by symptom(s)

    more than half the time

APPENDIX V

(FUNCTION IMPAIRMENT EVALUATION)

A symptom or a cluster of symptoms can affect the function of the patient as follows:

CODES:

0 = No effect on social or occupational activities

1 = Some impairment in social and occupational activities, but many activities are still intact

2 = Significant impairment of most or all social and occupational activities

The SCIP Follow-up Assessment

After the initial evaluation is completed and the patient is diagnosed with a certain disorder or disorders, follow-up visits focus on changes in symptoms, the patient's response to treatment, including medications, and the overall progress of the patient. For example, for a patient diagnosed with Major Depressive Disorder and a SCIP depression score of 20, follow-up visits should focus on depressive symptomatology and comparing depression scores over time. Clinicians also observe and assess the development of new symptoms over time, which may or may not affect the current diagnoses.

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