



# **TRAINING MANUAL**

## **DIAGNOSTIC INTERVIEW FOR PSYCHOSIS AND AFFECTIVE DISORDERS**

**Updated for OPCRIT 4.0  
DSM-IV & ICD-10 algorithms**

Center for Genomic Psychiatry  
Department of Psychiatry & the Behavioral Sciences  
Keck School of Medicine  
University of Southern California  
Los Angeles, CA

# **DIAGNOSTIC INTERVIEW for PSYCHOSES and AFFECTIVE DISORDERS**

## **DI-PAD QUICK REFERENCE GUIDE GPC: Genetics of Schizophrenia and Bipolar Disorder**

### **Purpose**

The purpose of the Diagnostic Interview for Psychoses and Affective Disorders (DI-PAD) is to collect and record information regarding a research subject's functioning and psychopathology with primary emphasis on information relevant to the study of the affective disorders and schizophrenia. The organization of the interview and the item coverage are designed to elicit information necessary for making rigorous diagnoses based on multiple diagnostic classification systems. The interview is suitable for use in genetic studies of probands and their relatives. It allows for assessment of present episode, worse episode, or lifetime symptomatology, although for the current studies, all evaluations will be based on lifetime symptomatology.

### **Personnel and Training**

The most suitable personnel for administering this instrument are individuals with experience in psychiatric clinical interviewing and making judgments about manifest psychopathology. Although most of the items are defined to ensure uniform criteria for all raters, the types of judgments called for require more knowledge of psychiatric concepts than do many of the more commonly used observational scales. Therefore, it is important that experienced clinical supervisors be available to closely supervise interviewers with less clinical training and/or experience.

The DI-PAD and the relevant diagnostic criteria should be studied in detail before use so that the interviewer understands the proper procedures for using the instrument, the criteria for judging the items, and knows the information needed for critical diagnostic distinctions. If this is not done, the initial interviews with subjects will be extremely awkward and unnecessarily long because the interviewer will not know when to skip over items or sections, when to interrupt the subject because he or she already has sufficient information, or whether the subject is providing information that is irrelevant with respect to making the required judgments. The only diagnostic classification systems being applied in these studies are the DSM-IV and the ICD-10.

Experience has shown that nothing is more valuable for training than conducting several interviews. Initially this can be done by having interviewer trainees try out the instrument on one another, with the person being interviewed assuming the role of a subject. Next, the trainee should observe an experienced interview conduct an interview while rating the DI-PAD in parallel. Following the interview, the two forms should be compared and discrepancies in scoring resolved. Next, the trainee conducts an interview with actual research subjects, preferably representative of those who will be examined in the research study. The initial 2-4 interviews conducted by the trainee

should be observed by a trained clinician making parallel, independent ratings. Following each supervised interview, there should be discussion of the trainee's interviewing technique and of all causes of disagreement in scoring. Each interviewer must be trained to competence. The number of interviews observed should be determined by the trainee's level of experience and skills. Across all sites, each interviewer will be assessed for consistency and accuracy every six months.

## **Data Sources**

If the subject is too disturbed initially, clinical observations should be made and the interview finished later when he or she is less disturbed. Judgments of interviewer rated items may be based more information than that obtained directly from the subject. Other sources of information (e.g., medical records, family informants, etc.) may be taken into consideration.

## **Interviewer Ratings**

The DI-PAD is not simply a self-report questionnaire. Correct use requires good interviewing skills and thorough knowledge of diagnostic systems. Coding of all responses should be made based on the interviewer's best clinical judgment, not necessarily on how the subject initially responds. Particular attention should be given to whether the item refers to subjective symptoms that the subject must acknowledge to someone (e.g., feelings of depression, complaints of memory impairment) or to behavior that is observable by others (e.g., incongruent affect, psychomotor agitation or retardation, behavior indicative that subject may be responding to internal stimuli).

Every item should be rated independently. For example, both retarded and agitated behavior may have been present during one period of illness. The interviewer should not infer the presence of an item (such as depressed mood), merely because of the presence of other items (such as lack of interest or other items in the depressive syndrome). However, should probe further if an initial denial of a symptom appears to be invalid. For many items, the most accurate coding will be based on the interviewer's ability to elicit specific, concrete behavioral examples that demonstrate the presence and severity of the symptom.

Every attempt should be made to rate each item, unless instructed to skip. If there is any information available, the interviewer should make his or her best clinical judgment about the presence of the symptom. When an interviewer is uncertain how a question should be coded, he or she should write enough information in the note boxes so that a decision can be made after the interview is completed.

Interview rated items must always be evaluated strictly in accordance with the strict diagnostic classification system used for these studies (DSM-IV or ICD-10 criteria).

## **Conducting the Interview**

The DI-PAD's semi-structured design gives interviewers the freedom needed to extract the best information possible, while also maintaining a standardized system of

interviewing. Whenever possible, bolded questions should be read exactly as written. Skipping phrases may change the content of the question. Long questions may need to be broken into two questions for some subjects. If the subject looks confused after the question is read, the interviewer should try re-reading the question before rephrasing. Questions can be rephrased or followed up with the recommended additional probes when a response does not seem appropriate for the question, leading the interviewer to suspect that the subject did not understand. The DI-PAD provides the interviewer with additional probes questions to be used if needed. Sometimes, subjects may volunteer information before a question is asked. When this happens, interviewers may then ask the question in a confirmatory way, but they should also pay careful attention to the subject's answer in case the information provided earlier is inconsistent or does not fit the question as it is worded.

The use of the instrument does not remove the interviewer's responsibility to be certain of the subject's replies. A symptom should not be rated as present simply because the subject says yes. A further description should be elicited, in the subject's own words, to make sure that the subject understands and is describing the symptom being rated. Similarly, if the subject says no, the interviewer must be certain that the symptom or behavior is not actually present. If there is strong evidence that the symptom is present, the symptom should be rated as present even if the subject denies its presence. For example, the subject is crying during the interview while denying current depressed mood, or denying symptoms of mania while displaying excessive pressured speech. When many symptoms are likely to be absent, the interview can be shortened by combining and abbreviating questions, such as "What about \_\_\_, or \_\_\_, or \_\_\_?"

As a retrospective lifetime report, the sequence of events or symptoms and their possible co-occurrence is critical in making accurate diagnoses. It is important that the interviewer have a clear chronological overview of significant events. The interviewer should frequently remind the subject of the time being considered with such questions as "The first time that you were sick, did you...?" "How bad did it get during that episode?" "How long did that last?" When assessing the symptom profile of specific episodes, prompts such as "during that time, did you also...." can be helpful to insure that both the subject and the interviewer are referring to the same episode.

## Privacy and Environmental Issues

The DI-PAD needs to be administered in private, where the subject can respond with complete candor without fear of others finding out about possible socially unacceptable, shameful, or unpleasant behaviors. If privacy is not possible in a subject's home, arrange to interview him/her in the research setting, or if necessary, in a quiet, secluded public setting, such as a private study room in a local library. The issue of privacy should be discussed at the time of the initial telephone or in-person contact. By privacy, we mean that there will be a place where the interviewer can talk to the subject without others hearing his or her responses (that is, it is okay if someone else is in the house at the time of the interview, as long as that person is out of earshot). If a person should walk into the room during the interview, the interviewer should stop speaking until the person leaves. Young children may pose a problem, in that the subject may not be able to give his/her complete attention. The interviewer will have to use his or her judgment in these situations. If the interviewer has any doubts about the situation, she or he

should call the site coordinator to get advice as to how to proceed. If an interview is being recorded for reliability purposes, the interviewer must refrain from saying the subject's name or any other information that could identify the subject.

## **Administration Exceptions**

Although this should be avoided whenever possible, in rare cases, some subjects may require the interview to be administered in two sessions. If you see the subject is unable to focus sufficiently on the questions or is otherwise struggling to complete the interview, continue only to the end of that module, then stop the interview and schedule an additional session to complete the interview. If you have concerns about the reliability of the information gathered near the end of the first session, those questions could be repeated and recoded if necessary at the beginning of the second session.

Under no circumstances should an interview be conducted while a subject is intoxicated on alcohol or under the influence of recreational substances. If you suspect this is the case, discontinue the interview and schedule for a later time. If you have concerns that the subject may be demented or so cognitively impaired that they are unable to provide reliable information, you may administer a brief mental status exam before deciding whether to conduct the interview.

## **Interviewer Ratings**

After the interview is completed, the interviewers should review his or her ratings and make changes whenever it is deemed appropriate. If necessary, the subject should be questioned further. Medical records and family informants may be used to provide supporting or clarifying information.

## **Coding Notes**

- Leave blank only those questions that were skipped by instruction.
- Ever = once or more
- Several = more than two
- Often = 3 or more times
- Frequently = 3 or more times
- Repeatedly = 3 or more times
- 99 = Unknown or too many to count
- Adolescence is defined as the period from ages 12 to 18.
- Age of onset = The earliest age at which psychiatric treatment was sought OR when symptoms began to cause subjective distress or impair functioning, whichever occurs first. A psychiatric hospitalization may identify age of onset, particularly when subject has poor insight. Record this information in the note box that queries about age and mode of onset.

- Age of offset = Age when no more than one symptom was present (see item 68 regarding residual symptoms).
- Whenever uncertain how to code, write enough information in the note boxes so that the diagnosticians can make an informed decision.
- Probe, remember as much as possible, be attentive to, and use good judgment to reconcile any inconsistencies. The coding system is to be followed strictly, whereas the proposed probing pattern is flexible; sometimes it will require more, sometimes fewer questions to be asked.
- Averaging can be minimized by interviewer's judgment. Examples:
  - If subject says 24 to 26 years old, code 25 to capture the mean.
  - In mania, a response of 0 to 2 hours of sleep should be coded 0 to capture the least amount.
  - In duration of mania, a response of 6 to 7 days should be coded up to capture the maximum amount.
- Whenever "specify" appears below a question, elicit, and record an example or description of the symptom or phenomenon that is the evidence for a rating. This convention forces the interviewer to ask for a description of the behavior rather than merely accepting "yes" to a question that may have been misunderstood. Particularly when bizarre or unusually idiosyncratic, record the subject's exact words in quotations.
- Two issues should be addressed when an organic factor is discovered to have preceded the onset of a syndrome. First, is the organic factor one that is known to be likely to cause the syndrome? Second, does the syndrome persist only in the presence of the organic factor? For example, a major depressive episode might occur following treatment with antihistamines; however, since there is no evidence that antihistamines can cause a depressive syndrome, it would be unreasonable to consider this organic factor as etiologic to the depression. On the other hand, while marijuana is known to be etiologically related to paranoia, an individual who begins to feel paranoid after smoking marijuana but continues to feel paranoid for months after discontinuing use could still be considered as having paranoid delusions (i.e., the organic exclusion criterion would not apply). If uncertain whether it is a true organic precipitant, it is preferable to code 0 (not present) and record as much detail as possible in the note box so that a decision can be made later. Exclude decisions for this reason will be made only by the site PI or designated diagnostician.
- Similar issues apply when psychiatric symptoms might be completely accounted for by alcohol or substance use. If significant comorbid alcohol or substance use is evident, record as much detail as possible in the note box regarding age and mode of onset so that a decision can be made later. Exclude decisions for this reason will be made only by the site PI or designated diagnostician.
- Differentiating depression and bereavement can sometimes be difficult. The duration and expression of "normal" bereavement varies considerably among different cultural groups. Dysphoric mood is generally not coded unless the symptoms are still present more than 2 months after the loss. However,

bereavement can extend well beyond the 2-month period without the grief being diagnostic for depression. However, the presence of certain symptoms that are not characteristic of a “normal” grief reaction may be helpful in differentiating bereavement from a Major Depressive Episode. These include:

1. guilt about things other than actions taken or not taken by the survivor at the time of the death;
  2. thoughts of death other than the survivor feeling that he or she would be better off dead or should have died with the deceased person;
  3. morbid preoccupation with worthlessness;
  4. marked psychomotor retardation;
  5. prolonged and marked functional impairment, and
  6. hallucinatory experiences other than thinking that he or she hears the voice of or transiently sees the image of, the deceased person.
- Depressive or manic symptoms should be coded as present or absent without any assumptions about what might have been present if the subject were not taking medication. Thus, if the subject was taking a sedative during a depressive episode and denied having any insomnia (initial, middle, or terminal), insomnia should be coded as absent.
  - Psychotic symptoms should be coded as present if they have been present at any time during the course of the illness. However, the duration still needs to be established.
  - If the answer to a question is obtained from information in previous sections, code the answer without asking the question.
  - For items that are re-coded, strike through the original entry and record corrected information in note box (paper version only).

## Danger to Self or Others

If at any point during the interview you suspect that the subject is at risk for suicide or homicide probe further. Always follow your own site’s risk assessment protocol.

- Always take the possibility of a suicide/homicide seriously.
- Always respond immediately.
- Never handle a suicidal/homicidal situation on your own.
- Never put yourself in any kind of danger.
- Only do what you are able to, and always get support for yourself.
- Follow your institution’s protocol on suicide/homicide risk management

## Child Abuse Reporting

During the interview, should you suspect that the subject is a perpetrator of child abuse, under all U.S. states laws, you are a mandated reporter. Please follow your own site’s protocol and state laws. Mandated child abuse reporting is not protected under the DHHS certificate of confidentiality.

## DI-PAD Do's and Don'ts

1. **Do** give the subject a brief explanation of the purpose of the interview before beginning. This will usually be part of obtaining informed consent.
2. **Don't** apologize for using a structured interview ("I have to read these questions. Most of them won't apply to you. Just bear with me. I have to give this standardized interview."). When the DI-PAD is properly administered, it is a clinical interview and needs no apology.
3. **Don't** ask in detail about specific symptoms that are covered in later sections of the DI-PAD.
4. **Do** stick to the initial questions, as they are written, except for minor changes to account for what the subject has already said, or to request elaboration or clarification.
5. **Don't** assume that you understand what the subject is describing when he or she uses vague or overly broad terms such as "I felt awful" or "It was overwhelming." Probe for additional descriptive information.
6. **Do** feel free to ask additional clarifying questions such as "Can you tell me more about that?" or "Do you mean that...?"
7. **Do** use judgment about a symptom, taking into account all of the information available, and gently confront the subject about responses that are inconsistent with other information.
8. **Don't** necessarily accept the subject's response if it contradicts other information or you have reason to believe the subject is giving you inaccurate information. If the inconsistencies are pervasive or significant, collateral information should be obtained.
9. **Do** make sure that the subject understands the questions. It may be necessary to repeat or rephrase questions or ask subjects if they understand you. In rare cases, it may be helpful to describe the entire syndrome you are asking about (e.g., a depressive episode).
10. **Don't** use words that the subject does not understand.
11. **Don't** use jargon or psychiatric nomenclature. Instead of saying, "when you were manic did you," say something like, "during that period when you were not sleeping and had too much energy did you..."
12. **Do** make sure that you and the subject are focusing on the same (and the appropriate) time period for each question.
13. **Don't** assume that the symptoms the subject is describing occurred simultaneously unless you have clarified the time period. For example, the subject may be talking about one symptom that occurred a year ago and another symptom that appeared last week, when you are intending to focus on symptoms that co-occurred during a 2-week period of a possible major depressive episode.
14. **Do** focus on obtaining the information necessary to judge all of the particulars of a symptom criterion under consideration. As noted above, this may require asking additional questions.
15. **Do** make sure that each symptom noted as present is diagnostically significant. For example, if the subject says that he has always had trouble sleeping, then that symptom should not be noted as present in the portion of the DI-PAD dealing with the diagnosis of a major depressive episode (unless the sleep problem became substantially worse during the period under

- review). This is particularly important when an episodic condition (such as a major depressive episode) is superimposed on a more chronic condition (such as dysthymia).
- 16. **Don't** continue to probe or question the subject when you have already obtained sufficient information to reliably code the response. Move on to the next question.
  - 17. **Do** maintain the pace of questioning sufficiently rapid to be efficient with your time without sacrificing the thoroughness of your interview.
  - 18. **Do** attend to developing an empathic rapport with your subject.
  - 19. **Do** be professionally attentive and sensitive to your subject's emotional state during the interview.
  - 20. **Do** make sure your handwriting is legible, especially when recording medications (paper version) and that the names of medications are spelled correctly.

## Definitions

**Thought Echo** – (item 49) a form of auditory hallucination in which the subject hears his or her thoughts spoken aloud, either simultaneous with thinking them or a moment or two afterwards. The subject hears the “echo” of the thoughts in the form of a voice after he or she has produced the thought. Thoughts are heard as if spoken aloud and may be repeated over and over. A thought echo is an auditory hallucination and is not the same as the obsessive repetition of a single thought that is often seen in Obsessive-Compulsive Disorder.

**Delusional Mood** – (item 58) a state of perplexity in which the subject has some sense of some inexplicable change in his or her environment. A strange mood in which the environment appears changed, but the significance of the change cannot be understood by the subject, who is usually tense, anxious, or bewildered. The subject senses “something going on” which he or she cannot identify, but which has a peculiar personal significance. A feeling that something unusual is about to happen, which has special significance for that person. In subjects with paranoid ideation, this feeling may be one of foreboding, impending threat, or doom. The environment as perceived by the patient is felt to change into a puzzling, mysterious, or stage-like scene. Delusional moods are rare and seen more often in the initial stages of schizophrenia. If in doubt, rate this item down.

**Formal Thought Disorder** – (item 82) applies specifically to a persistent disruption or disorganization in the flow of conscious verbal thought and is inferred from spoken language. There is a lack of logical association between succeeding thoughts that gives rise to incoherent speech (in the absence of brain pathology). It is nearly impossible to follow the subject’s train of thought. Speech may be fluent, but communication is poor. Examples of types of disordered speech associated with formal thought disorder are:

- **Pressure of speech** - An increase in the amount of spontaneous speech compared to what is considered customary. Note: rapid speech that is appropriate, linear, and goal directed is not considered formal thought disorder.
- **Distractible speech** - During mid speech, the subject is changed in response to a stimulus (e.g. “Then I left San Francisco and moved to... where did you get that tie?”).
- **Tangentiality** - Replying to questions in an oblique, tangential, or irrelevant manner (e.g. “What city are you from?” “Well, that’s a hard question. I’m from Iowa. I really don’t know where my relatives came from, so I don’t know if I’m Irish or French.”).
- **Derailment** - Ideas slip off the track on to another, which is obliquely related or unrelated (e.g. “The next day when I’d be going out you know, I took control, like uh, I put bleach on my hair in California.”).
- **Incoherence (word salad)** - Speech that is unintelligible due to the fact that, though the individual words are real words, the manner in which they are strung together results in incoherent gibberish (e.g. the question “Why do people believe in God?” elicits a response like “Because make a twirl in life, my box is broken help me blue elephant. Isn’t lettuce brave? I like electrons, hello.”).

- ***Illogicality*** - Conclusions are reached that do not follow logically (non-sequiturs or faulty inductive inferences).
- ***Clanging*** - Sounds rather than meaningful relationships appear to govern words (e.g. “I’m not trying to make noise. I’m trying to make sense. If you can’t make sense out of nonsense, well, have fun.”)
- ***Neologisms*** - New word formations (e.g. “I got so angry I picked up a dish and threw it at the geshinker.”).
- ***Word approximations*** - Old words used in a new and unconventional way (e.g. “His boss was a seeover.”)
- ***Circumstantiality*** - Speech that is very delayed at reaching its goal. Excessive long-windedness.
- ***Loss of goal*** - Failure to show a chain of thought to a natural conclusion.
- ***Perseveration*** - Persistent repetition of words or ideas (e.g. “I’ll think I’ll put on my hat, my hat...”).
- ***Echolalia*** - Echoing of other people’s speech (e.g. “Can we talk for a few minutes?”, “Talk for a few minutes.”)
- ***Blocking*** - Interruption of train of speech before completed.
- ***Stilted speech*** - Speech excessively stilted and formal (e.g. “The attorney comported himself indecorously.”).
- ***Self-reference*** - Patient repeatedly and inappropriately refers back to self (e.g. “What’s the time?”, “It’s 7 o’clock. That’s my problem.”).
- ***Phonemic paraphasia*** - Mispronunciation or syllables out of sequence (e.g. “I slipped on the lice broke my arm.”).
- ***Semantic paraphasia*** - Substitution of inappropriate word (e.g. “I slipped on the coat, on the ice I mean, and broke my book.”).

Andreasen, N. (1979). Thought, language, and communication disorders. I. Clinical assessment, definition of terms, and evaluation of their reliability. *Archives of General Psychiatry*, 36, 1315-1321.

# Frequently Asked Questions

## How do I conduct the psychiatric overview?

Beginning with item 5 (age of onset) and item 6 (mode of onset), an open-ended format should be used to elicit a brief overview of the subject's psychiatric history. The overview is an open-ended history of emotional problems that the subject acknowledges.

For subjects who are able to give a succinct or clear narrative account, beginning with a brief overview will guide and speed up the interview. The overview is also important in providing information about a subject's premorbid level of work (item 9) and social functioning (item 10).

The overview will vary in length; for most subjects with psychopathology, it should take about 10 minutes to complete. However, if the subject is better able to provide reliable information in an open format style, additional time should be spent on the overview to elicit the data necessary to reliably complete some of the remaining DI-PAD items. If there are several different problem areas, ask about them in order of apparent relevance to the study.

For those subjects who do not acknowledge any problems or whose insight is fair to poor, the interviewer may need to ask additional probing questions and ask the subject to expand on any positive responses. Other subjects may offer an overly detailed litany of complaints. You will need to gently redirect them to a question-and-answer style after allowing them a few minutes to establish a rapport.

The overview should include a brief note of significant symptoms, treatments, comorbidities, etc., in either a narrative or a timeline style. The important points to determine, prior completing the overview are:

1. presence or absence of psychosis
2. presence or absence of affective syndromes
3. presence or absence of alcohol or substance abuse
4. chronological relationship between items 1, 2, and 3
5. first and most recent psychiatric hospitalizations
6. other significant events (e.g., suicide attempts)
7. psychiatric medications (past and present)
8. mental health professionals seen (i.e., type and how many)
9. (if applicable) when the most severe episodes of major depression or mania occurred in relation to the other psychiatric disturbances
10. possible organic precipitants or confounds (e.g., epilepsy, traumatic brain injury, CNS disorder, etc.)

The overview is intended to guide your subsequent questioning and to allow you to complete the interviewer rating items. The best way to do this is to carefully familiarize yourself with these rating items (items 64 to 83) before you begin the interview.

- H. Interviewer Ratings of Psychotic Symptoms
  - 64. Well organized delusions
  - 65. Widespread delusions
  - 66. Delusions and hallucinations last for one week
  - 67. Persecutory or jealous delusions and hallucinations
- I. Interviewer Ratings of Duration and Course
  - 68. Duration of illness in weeks
  - 69. Impairment or incapacity during disorder
  - 70. Deterioration from premorbid level of functioning
  - 71. Course of disorder
  - 72. Rapport
  - 73. Credibility of information
- J. Interviewer Ratings of Behavior and Affect
  - 74. Catatonia
  - 75. Bizarre behavior
  - 76. Agitated activity
  - 77. Restricted affect
  - 78. Blunted affect
  - 79. Inappropriate affect
  - 80. Speech difficult to understand
  - 81. Speech incoherent
  - 82. Positive formal thought disorder
  - 83. Negative formal thought disorder

## **How do I determine age of onset?**

Sometime this can be difficult to ascertain. Age of onset is defined as the earliest age at which psychiatric treatment was sought OR when symptoms began to cause subjective distress OR when symptoms begin to impair functioning, whichever occurs first. Sometimes, the date of first hospitalization or other significant event (such as an arrest for disruptive manic behavior) will provide information that will help ascertain age of onset. Code the earliest age ascertained.

Note that the focus of the DI-PAD interview is on affective and psychotic symptoms. If a subject reports other, unrelated psychiatric symptoms, continue to probe until you ascertain the presence of symptoms relevant to this study. For example, if a subject reports Attention-Deficit Hyperactivity Disorder (ADHD) at age 8, and then clinically significant psychotic symptoms at age 17, then code age 17.

## **Why is understanding the subject's chronology so important?**

Understanding the chronological sequence of events is very important for a number of reasons.

The first is so that interviewer ratings are as accurate as possible. Retrospective self-reports will always contain some uncertainty, but eliciting a careful chronology will minimize potential errors.

Eliciting information in chronological order may help a subject date particular events. If a subject has difficulty remembering, suggesting a relationship to other autobiographical events may help the subject date an event more accurately.

Examples:

- “Did this happen before or after your family moved to...?”
- “Were you still in high school when this happened?”
- “What season of the year was it when that happened?”
- “Can you remember if it happened before or after your sister’s accident?”

Second, several of the inclusion and exclusion criteria require an understanding of the sequence of events to accurately determine eligibility. This is discussed more in the next section on comorbid alcohol or substance use.

A timeline is a valuable tool and can be used to clarify issues, such as organic precipitants, comorbidity, and the relationship between affective and psychotic symptoms that is necessary to the differential diagnosis of schizoaffective disorder.

## **What do I do when there is comorbid alcohol or substance use?**

Although there are no DI-PAD sections that assess for alcohol or substance abuse or dependence, the inclusion/exclusion criteria for the GPC studies state:

*Diagnosis of alcohol or substance dependence within one year of onset of psychiatric symptoms that confounds the diagnosis of schizophrenia. These will be case-by-case include/exclude decisions based on temporal relationship and clinical judgment of each site PI or designated diagnostician.*

Data from the screening questionnaire may offer indications that further questioning is required. Questions 12 through 17 ask about alcohol use. Questions 28 through 31 ask about substance use. If significant alcohol or substance use is detected from the questionnaire or during the overview discussion, probe further to ascertain the quantity and duration of use, severity of impairment, and (very important) the chronological relationship of alcohol or substance use to the mood or psychotic symptoms.

If you suspect that alcohol or substance dependence (not merely abuse) may confound a diagnosis of schizophrenia, collect as much information as possible, and then discuss the case with your clinical supervisor or site diagnostician. You may find it helpful to interview the subject using the optional DI-PAD alcohol and substance use module and complete the associated interviewer ratings. This module was designed specifically to assess alcohol and substance dependence. If this module is completed, the ratings will then be included in the OPCRIT diagnostic algorithms.

## **How do I rate the credibility of information collected?**

Rate item 73 based on both the apparent candor and accuracy of the information obtained in the interview along with the credibility of information obtained from collateral sources. Make careful notes explaining your concerns, if any, about the accuracy of the interview. Medical records or family collateral information may need to be requested if the subject is unable to provide a credible self-report.

If a subject appeared to be candid during the interview but had minor difficulty recalling specific dates, details of symptoms, or reported small inconsistencies, the information should still be considered credible.

If the subject was reluctant or less than completely cooperative, but offered information that you think is generally accurate, rate the information as credible.

If a subject cannot provide minimally credible or reliable information and no collateral data is available, item 73 should be marked "information not credible" and the subject will be excluded from the study.

If you have other serious concerns about the integrity or accuracy of the data in its entirety, item 73 should be marked "information not credible" and the subject will be excluded from the study.

## **Which depressive and/or manic episodes do I select to code?**

Section C (depression) and Section D (mania) symptoms are each coded in relationship to one specific mood episode. The interviewer determines which episode to code in collaboration with the subject. Based on the overview or additional probing, identify the most recent severe episode that the subject remembers well. Most often, this will be the episode that you select to code. If the subject is uncertain about the most severe episode, probe for the episode that caused the most severe impairment (i.e., hospitalization, job absence, loss of marriage, etc.) or one that contained psychotic symptoms. Whenever possible, try to avoid coding episodes with likely organic or chemical precipitants. Ideally, the coded episode should be a recent, typical, and severe episode that the subject can recall well.

It is neither necessary or desirable to collect detailed symptom information about all of the subject's depressive or manic episodes. Doing this only serves to prolong the interview unnecessarily. Once you select a single episode to code, focus the questioning solely on that episode.

## **How do I calculate the duration of illness?**

When coding the duration of illness (item 68), treat psychosis as a single episode. Ask about the year prior to the onset of the first psychotic symptoms and the year following the most recent active phase episode. Remember that the maximum you may code is 99 weeks, which is less than two years. If it is clear that the illness has exceeded this period, it is not necessary to ascertain duration of prodromal or residual symptoms.

## **What is prodromal phase and residual phase?**

A prodromal phase represents a clear deterioration in functioning before the active phase of psychosis that is not due to a disturbance in mood or to a psychoactive substance use disorder. A residual phase is one that follows the active phase of psychosis and is a clear deterioration in functioning that is not due to a disturbance in mood or to a psychoactive substance use disorder.

- The prodromal period refers to the period prior to the onset of the active psychosis. This may be less than 1 year.
- The residual period refers to the period after the active psychotic phase. This also may be less than 1 year.

Some items that are included when determining the prodromal and residual periods may overlap with active symptoms. One distinction between active and prodromal symptoms is the intensity of the subject's conviction that these experiences are true or real.

**IMPORTANT:** Remember that all psychotic symptoms are coded if they have EVER occurred during the subject's lifetime. If there are multiple psychotic episodes with a true return to full premorbid functioning (two months or more) in between, you may frame your questions in reference to the most recent or most severe psychotic episode. This will often be the most well-remembered episode.

## **What if I'm not sure whether or not I should skip a module?**

Most of the symptom modules begin with several key "gate" questions that define symptoms essential to making a particular diagnosis. If those symptoms are not present, then that particular diagnosis can't be made and you will be instructed to skip to the next section. The gate questions are deliberately broad so as not to unduly restrict the diagnoses. For example, in section C (depression) subjects are asked if they have ever experienced at least one week of persistent sadness, anxiety, irritability, or apathy/anhedonia. A "yes" response to any one of these is sufficient to proceed with the section. If the subject is uncertain or answers "no" to the gate questions, but has revealed other information that suggests there might have been an episode of depression, then code "yes" for either item 14 or item 15 and explain why depression is suspected. Then proceed with the rest of the questions in that section.

If there is doubt about the presence of these symptoms, then the interviewer should continue with the section and document the most severe episode (depression and mania) or most severe lifetime symptoms (psychosis).