Investigators wishing to use the PRISM should contact Dr. Deborah Hasin, New York State Psychiatric Institute/Columbia University, 1051 Riverside Drive - Unit 123, New York, New York 10032, (212) 923-8862, dsh2@columbia.edu.

Investigators working in nonprofit or publicly owned settings (including universities, non-profit hospitals, and government institutions) may make photocopies of the PRISM 6.0 Manual for their own research purposes.
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General Introduction to the PRISM 6.0

What is the PRISM?

The PRISM 6.0 is the Psychiatric Research Interview for Substance and Mental Disorders; a semi-structured diagnostic interview designed to deal with the problems of diagnosis when subjects/patients drink heavily or use drugs. The PRISM 6.0 assesses 20 DSM-IV Axis I disorders and 2 Axis II disorders. With this interview, you will be able to differentiate primary disorders, substance-induced disorders and the expected effects of intoxication and withdrawal.

The PRISM 6.0 is generally used in clinical and treatment studies and can be used to follow subjects in longitudinal studies. This version of the PRISM takes approximately 2 hours to administer once interviewers have become familiar with the interview. The range of time required depends on the complexity of the substance use and psychiatric history.

History of the PRISM

Several general-purpose diagnostic interviews have been developed to assess the main adult psychiatric disorders as defined by the different sets of diagnostic criteria such as DSM-IV. However, understanding and treating co-morbid alcohol, drug, and psychiatric disorders has become increasingly important and the diagnosis of psychiatric disorders in individuals with heavy alcohol or drug use has been problematic. To address the lack of a diagnostic interview that was suitable for co-morbidity research the PRISM was begun in 1990 with a grant from the National Institute of Alcohol Abuse and Alcoholism. This early version of the PRISM provided new features specific to co-morbidity.

The PRISM was subsequently revised to improve reliability, usability, and to focus more thoroughly on issues of co-morbidity based on the findings from earlier studies. A test-retest reliability study of this version of the PRISM, showed very good results (Hasin, et. al., 1996). Probes have since been revised in order to shorten the time needed to administer the instrument (Hasin, et. al., 1998). The alcohol and drug sections have been combined to streamline administration. Questions are provided in the Mood and Psychotic Disorders sections that ascertain the temporal relationship of mood or psychotic symptoms and substance use (Miele, et. al., 1996). The psychotic symptom section has been expanded to make diagnoses of specific psychotic disorders rather than the more global rating of “psychotic symptoms”, including substance-induced psychotic disorders (Caton, et. al., 2000).
Features of the PRISM

Obtains overview of lifetime psychiatric treatment history
Obtains history of heavy drug and alcohol use prior to other diagnostic sections
Obtains lifetime timeline of periods of heavy substance use and abstinence
Assesses lifetime and current psychiatric symptoms and disorders
Provides guidelines to assist in differentiating substance-induced from primary symptoms
Provides guidelines to assist in determining the temporal relationship of psychiatric symptoms and substance use.

Allows for interviewer or computer diagnosis

How does the PRISM increase reliability?

The PRISM provides specific rating guidelines throughout the interview, including frequency and duration requirements, exclusion specifications, and decision rules. Standardized probes are provided to explore the subject’s responses. A computer program used to formulate a diagnosis from the interview data reduces error and does not rely on rater opinion. A training package, consisting of this manual, pre-scripted role-plays, and other training aids, standardize training.

How are data collected, recorded, and analyzed using the PRISM?

Data are collected through face-to-face interviews with subjects and coded on the PRISM booklet. The PRISM is a contingency questionnaire, routing interviewers to relevant questions depending on subject responses. Therefore, although the instrument allows for the investigation of many variables, only a subset of PRISM questions is administered to any single subject. PRISM data entry, data cleaning and diagnostic computer programs are available. The data is entered using Microsoft Access-based data entry software. Cleaning and diagnostic programs are written in SAS.

What does the PRISM data cleaning software do?

The SAS cleaning program for the PRISM is designed to identify logical inconsistencies and missing data. Checking that the skip patterns of the interview are followed correctly ensures that none of the questions to be coded are erroneously left blank. In addition, the program crosschecks responses (i.e. when the response to one item is dependent on the response to another item, the two responses are compatible). When the cleaning program is run on the data set, it generates a printout. This printout contains a list of the specific errors. A research assistant can then check the interview and the data set to locate the error. Sometimes, when the error is corrected, it can uncover another error because of the branching logic of the interview. Therefore, the cleaning program should be run at least one more time after initial corrections have been made.
What does the PRISM diagnostic software do?

The SAS diagnostic program evaluates PRISM interview data for the presence of substance-induced and primary disorders. The program makes diagnoses according to DSM-IV criteria. Each program has extensive internal documentation of (1) the criteria used to make the diagnosis and (2) the logic of the program. The diagnostic program creates variables that represent each DSM-IV criterion for a disorder, and then combines them according to the DSM-IV logic to produce a diagnosis that takes into account exclusion criteria.

Who can administer the PRISM?

Interviewers with different professional backgrounds can administer the PRISM. Past trainee groups have included individuals with bachelor’s degrees in psychology, nursing degrees, and graduate degrees in psychology or a related discipline. Interviewers should have some work or training experience with substance-using and psychiatric populations.

References


PART 1

PRISM ELEMENTS
Introduction

When psychiatric problems occur during a period of heavy and prolonged substance use, diagnosis can become difficult. The PRISM is designed to make co-morbid diagnosis more straightforward and more reliable. In this chapter, we introduce the three main concepts of PRISM co-morbid diagnosis.

Three Main Concepts

The three main concepts of PRISM co-morbid diagnosis are:

Expected Effects of Intoxication and Withdrawal
Substance-Induced Disorder
Primary Mental Disorder

CONCEPT 1: Expected Effects of Intoxication and Withdrawal

The first concept in PRISM diagnosis is the concept of the expected effects of intoxication and withdrawal. The expected effects of intoxication or withdrawal are the predicted physiological effects of substance abuse and dependence. These effects are reflected in the substance-specific symptoms of intoxication and withdrawal syndromes for each of the main categories of substances (e.g., amphetamines, hallucinogens). See DSM-IV (pp. 183-272) for symptoms of these syndromes for each substance category.

The effects of substance intoxication and withdrawal can sometimes appear to be identical to the symptoms of primary mental disorders, e.g. insomnia, diminished ability to concentrate, and hallucinations.

CONCEPT 2: Substance-Induced Disorder

The PRISM concept of a substance-induced disorder is more specific than DSM–IV Substance-Induced Mental Disorder. In the PRISM, the disorder is diagnosed as substance-induced when:

1. All DSM–IV symptom criteria for the disorder are met;
2. The episode occurs entirely during a period of heavy substance use OR within the first four weeks after cessation of use;
3. The substance used is “relevant” to the disorder (i.e., its effects can cause symptoms mimicking the disorder being assessed);
4. The symptoms are greater than the expected effects of intoxication and/or withdrawal.
To differentiate symptoms of Major Depression from intoxication/withdrawal effects, the interviewer must determine if there is a significant change in use (i.e., increases, decreases). The PRISM provides guidelines on how to make this differentiation. Using the guidelines, which refer to the timing of changes in symptoms from the substance-using baseline, you will be able to identify symptoms in the heavy substance user that corresponds more to depressed mood than to substance use.

To differentiate a psychotic symptom related to a primary psychotic disorder from intoxication/withdrawal effects, the PRISM assesses the person’s awareness of the drug effect at the time psychotic hallucinations occurred. The PRISM provides coding guidelines and probes for making this differentiation.

CONCEPT 3: Primary Mental Disorder

A Primary Mental Disorder is diagnosed when an episode (e.g., major depression) occurs during a period of abstinence or only occasional substance use. Note that at least a significant portion of the episode must occur when the subject is not using substances at all, or not enough to cause intoxication or withdrawal from a substance.

In the PRISM, a primary mental disorder can occur under three different circumstances:

1. The episode occurs during a sustained period of abstinence or occasional substance use;
2. The episode begins at least 2 weeks prior to the onset of heavy substance use;
3. The episode begins during heavy substance use and continues for 4 or more weeks after cessation of use.

Thus, at least a significant portion of the episode occurred when the expected effects of intoxication or withdrawal could not have occurred.

Definition of Terms

To assure that people are using clinical terms consistently, the PRISM provides specific definitions of terms related to substance use and co-morbidity. These terms include:

- **chronic intoxication** - substance use 4 or more days a week for 3 or more weeks;
- **binge** - 3 or more days of continuous substance use;
- **occasional use** - substance use less than 4 days a week (unless substance was used in a binge pattern);
- **withdrawal** - the 4-week period following cessation of chronic intoxication or binge use;
- **relevant substance** – a substance is considered to be relevant to mental disorders when intoxication or withdrawal from that substance can result in symptoms that are similar to the symptoms of the mental disorder.

The focus of substance use is primarily on frequency (i.e., how often a subject uses a particular substance during a one-week period). Alcohol is the only substance that is also assessed quantitatively. That is, if the person drank only small amounts of alcohol (less than 4 drinks) and did not use any other substance, this would not be considered “chronic intoxication” in the PRISM.
Substance Use Disorders

In the PRISM, Alcohol and Drug assessment is done in two separate but related sections, Substance Screening and Substance Use Disorders.

In Substance Screening:

- Screen for lifetime use of alcohol and drugs
- Obtain a chronological history of use

In the Substance Use Disorders Section:

- Inquire about symptoms of abuse and dependence
- Inquire about the course of abuse and dependence

Mental Disorders

In the Mental Disorder Sections:

- Screen for a potential mental disorder
- Inquire about substances and other causal factors
- Inquire about the symptoms of the disorder
- Inquire about significant impairment or distress
- Inquire about the course of the disorder

Most diagnostic sections of the PRISM contain a screening section, followed by symptom questions and course questions. The screening varies from section to section based upon specific diagnostic criteria.

Screening

Most PRISM sections begin with screening questions. These screening questions assess the presence of potential psychiatric disorders in the subject’s lifetime. The most important purpose of the screening questions is to serve as a “gateway” into the sections.

Symptoms

Disorders consist of a constellation of symptoms. In most sections, there is a list of associated symptoms. The subject needs a specific number out of the total list to meet symptom criteria for the disorder.
Impairment/Distress

When symptom criteria for a disorder have been met, the subject is assessed for impairment and/or distress in occupational or social functioning. Impairment or marked distress is required to receive a diagnosis in most categories. For the majority of disorders, the subject will be asked if impairment/distress is mild, moderate or severe. This criterion is met when a subject reports moderate or severe impairment/distress (coded “3” or “4”).

Rule Outs

In the case of psychiatric diagnosis, there are several rule out scenarios that are assessed. Examples of these include bereavement, physical illness or a medical condition, exposure to a toxin, and disorders related to prescription medications. Of course, a Primary Disorder is ruled out if it is considered substance-induced.

Course

Course questions obtain the initial onset of symptoms, information about a partial or full remission from symptoms, and dates of onset and offset of the most recent episode of the disorder. Before asking course questions, briefly review with the subject those symptoms reported.
Three-Column Pages

The PRISM is set up in a three-column format. The middle column contains the intent of the item (DSM-IV symptom or criterion), and guidelines for assessing this. The left column contains the probes. The right column provides space for coding the subject’s responses.

The Middle Column

Each question to be coded has a general heading in the middle column. The heading may be a DSM-IV criterion, or it may explain the intent of the probe. Under this heading is a list of bullets. These bullets contain severity, frequency, and duration criteria for symptoms. They also contain guidelines for coding more complex responses.

The Left Column

The left column contains the probes or questions. The PRISM has two different types of probes:

Type 1: Required Probes

The first type of probe is the required probe. You must ask these questions unless you already know the answer from previous questioning.

a. Alternative Phrasing

Terms or statements in the required probe are sometimes found in parentheses. The parentheses indicate that you may alter the phrasing. For example, in PRISM 6.0 Section 4A, Q 17, (p.40), the terms “depressed/anhedonic” are found in parentheses. This means that you may choose the best way to ask the question.

b. Subject’s Own Equivalent

The term “SOE” (subject’s own equivalent) often appears in parentheses in the required probe (see PRISM, Q 16, p.3). The (/SOE) convention reminds you to use the subject’s own word or expression whenever possible, as long as the meaning of the word is clearly understood. Using a subject’s own words increases the certainty that the subject fully understands the question and minimizes the risk of making a subject feel stigmatized.
Type 2: Follow-up Probes

The second type of probe are follow-up questions that appear in parentheses. You do not always need to ask all of them. The follow-up probes are used if a response needs confirmation or clarification.

Left Column Arrows

In several instances, the probe in the left column is substituted by an arrow pointing to the middle column (“———> “). This convention is used when:

1. the correct code should be apparent (see PRISM, Q 1, p.1); or,
2. when the symptom or criterion has been completely covered earlier in the interview, and the answer needs to be brought forward (see PRISM, Q 42, P.51).

The Right Column

Subject responses are coded in the right column. There are a number of formats for coding. Codes are presented as numbers in horizontal format and in vertical format. There are also blank spaces for numerical responses.

Coding Format: Horizontal and Vertical Numbers

Code 1, 2, and 3 in horizontal and vertical format is the most common type of format in the interview. A code of 4 and “?” are also provided in certain instances.

a. “1” Code

A question is coded “1” when a subject says “no” or when a response does not match the middle column at all. In symptom questions, a “1” means the subject did not have the symptom. For example, John reported that he never drove a car after drinking. So, Q 1 (PRISM, p. 12) would be coded “1” for alcohol in both time periods.

b. “2” Code – Sub-threshold Response

A question is coded “2” when the subject reports the general experience defined in the middle column, but the specific frequency, severity, or duration of the experience does not match the middle column. This is called a sub-threshold response. For example, Susan reported that she drove a car after drinking, but it only happened twice in the last year and never in the past. In this case, Q 1 (PRISM, p. 12) would be coded “2” for alcohol in the “last 12 months” column and “1” in the “prior to the last 12 months” column.

c. “3” Code - Threshold Response

A question is coded “3” when the subject reports an experience that matches the definition and the required level of severity, frequency, and duration listed in the middle column. This is called a threshold response because it meets the symptom criteria. For example, Jim reported that he drove a car after drinking at least six times in the last year and more frequently in the past. In this case, Q 1 (PRISM, p. 12) would be coded “3” for alcohol in both columns.
“4” Code – Intoxication/Withdrawal Response

The Depression, Mania, and Psychosis Sections (4, 6, and 8, respectively) contain the “4” code option in symptom questions. A question is coded “4” in two instances. A symptom is coded “4” when the subject meets symptom criteria, but this occurs with an increase or decrease in substance use. This response is considered to be the expected effects of intoxication and/or withdrawal. For example, Susan began to feel severely depressed shortly after a significant increase in her cocaine use. She reported a decrease in appetite and significant weight loss during this time. Since appetite and weight loss are the expected effects of cocaine intoxication, Qs 20 and 21 (PRISM, p. 42) are coded “4” in the relevant time frame.

Another example of expected effects occurs when a subject is aware their substance use caused psychotic symptoms. Jim heard voices while high on crack. He recognized his perceptions were caused by his crack use and did not act on these voices. In this case, auditory hallucinations are coded “4.”

The “4” code can also be used if the subject becomes depressed during a period of steady state use, the symptom was present before the depression began, and continued unchanged during the period of depression. For example, Jim experienced severe depression during a period of heavy cocaine use. His insomnia was present before he became depressed, and did not worsen after he became depressed. Since the insomnia follows the course of the cocaine use, not depressed mood, Q 24 (PRISM, p. 43) is coded “4.”

A symptom coded “4” is never included in the symptom count toward the diagnosis for Major Depression, Mania, or Psychosis.

e. “?” Code

Use the “?” code only when the subject can’t remember the entire period in question or flatly refuses to answer the question. Often, the subject can remember but is concerned that his/her information is not specific enough. In these cases, ask the subject for a best estimate. Often, the subject can recall the time in question but can’t recall having a particular experience. In this case, the question is coded “1”, not “?”. 

Coding Format - Blank Spaces

Blank spaces in the right column require you to fill in a number. Use whole numbers only. If the subject is not specific about the number of days, ask for a best estimate. The number range for this convention (‘days,’ ‘weeks,’ and ‘months’) is 1-65. This convention is frequently used in the PRISM for questions about the course of a disorder (e.g., onset and offset).

_____ DAYS AGO

OR

_____ WEEKS AGO

OR

_____ MONTHS AGO
Other Prism Conventions

Interviewer Statements

Interviewer Statements are transitional statements that introduce the subject to the next set of questions. For example, in PRISM Section 2 (p. 9), Statement B.1 reads “Now I’d like to ask you some questions about your drinking and drug use.” These statements must be read aloud, as written, by the interviewer to orient subjects to the upcoming material.

Large Boxes

In the PRISM, complex symptoms in DSM-IV are broken down into discrete parts. This produces simpler, separate questions. Multiple questions representing an individual symptom are grouped together into a large box. When any question in a large box is coded “3,” the symptom represented by that box is counted towards the diagnosis. For example, Qs 20-23 (PRISM, p. 42) represent changes in appetite and weight. If Q 21, significant weight loss, was coded “3,” the symptom of change in appetite and weight is included in the Major Depression diagnosis.

Small Boxes

Throughout the PRISM, small boxes must be checked in addition to coding options. These boxes provide information in addition to the “3” code regarding symptoms, substance use, diagnoses, and impairment. For example, Q9 (PRISM, p. 36) asks if the subject was abstinent or used substances occasionally during the entire time they were depressed. If the subject answers this question in the affirmative (“3” is coded), the small box indicating abstinence or occasional use must be checked.

Start Time/End Time

At the beginning and at the end of each PRISM section, there is a line to indicate the time the section was started and completed.
PART 2

PRISM SECTIONS
Purpose

The Overview (PRISM, Section 1, pp. 1-8) is the introduction to the PRISM interview.

The three aims of Section 1 of the PRISM are:

1. The process of going through the Overview with the subject helps to establish rapport and set the tone for the rest of the interview.

2. Many of the questions included in the Overview provide an opportunity to discover circumstances or events possibly indicative of psychopathology. Some of the questions inquire directly about the individual’s psychopathology (e.g., type of treatment, reasons for treatment). Other questions are intended to uncover preliminary indicators of psychopathology indirectly by asking about possible impairment in a variety of areas of functioning (e.g., periods of unemployment, interrupted educational programs).

3. The information can be of research interest in its own right.

Structure

Demographics

Questions 1-21 of the Overview include questions about age, ethnicity, marital status, number of children, legal guardianship, education, household occupants, past and current employment, military service, and current medical status.

Treatment History

Questions 22-30 cover medical, psychiatric, psychological, and psychopharmacological treatment. The middle column provides coding guidelines for the types of treatment and treatment facilities. Questions about alcohol and drug treatment are followed by questions about participation in 12-step or other self help groups.

Question 30 is designed to identify possible psychopathology even if no treatment was sought for a problem.
Special Attention

Q5 – If coded greater than “1,” subjects must be asked if they were ever divorced or widowed (Qs 6-7).

Q25c, 26c, 27c, 28c, 29c – If the subject is currently in treatment, check the “current treatment” box and code “1 day ago.”
PRISM 6.0 Section 2: SUBSTANCE SCREENING

Purpose

The Substance Screening section is the first diagnostic screening section of the PRISM. Its placement at the beginning of the interview signals the importance of section. This is one of the most important sections of the PRISM because the information gathered in this section is used to determine whether episodes assessed later in the interview are considered primary, substance-induced, or as the expected effects of intoxication or withdrawal.

The two aims of Section 2 of the PRISM are:

1. To Make A Preliminary Identification of Subjects With Substance Use Problems

   The Substance Screening Section (PRISM, pp. 9-11) identifies all subjects who may have had any problems with alcohol and/or drugs in the last 12 months, or prior to the last 12 months. The screening questions are designed so that subjects who report any substance problems, even if very mild, will be routed to Section 3 to assess DSM-IV alcohol and drug abuse and dependence.

2. To Provide A Substance Use History

   Another function of PRISM Section 2 is to provide a clear picture of the subject’s substance use history. This will be the framework for assessing symptoms when going through the substance use diagnostic section (PRISM Section 3) and the rest of the interview. The substance use timelines charted in this section will be used later in the interview in the important task of differentiating primary mental disorders, substance-induced mental disorders, and the expected effects of intoxication and withdrawal.

Structure

The substance screening section is organized into three sub-sections. In the first section (Qs 1a, 1b, and 2), subjects who may have had drinking or drug use problems in the last 12 months and in the past are identified. The second section (Qs 3 and 4) assesses chronic intoxication and binge use of alcohol and/or drugs. In the third section, a substance use history is obtained for construction of timelines including onset of use, changes, and periods of abstinence. Qs 6-16 in this section are not coded as this data is only used for purposes of constructing timelines.
**Screening**

The Substance Screening includes alcohol and nine drug classes: Cocaine; Heroin; Cannabis; Hallucinogens; Sedatives; Stimulants; Opiates; Methadone; and Other Drugs. Other Drugs includes drugs of abuse and prescription drugs that are used more than prescribed (e.g., thorazine, glue, amyl nitrate).

In the substance screening section, determine if the subject passed screening for a substance and whether or not to proceed with the Timeline and symptom inquiry. These questions inquire about use in the last 12 months, and prior to the last 12 months.

Alcohol is the only substance that is also assessed quantitatively in the PRISM. That is, if the person drank only small amounts of alcohol (less than 4 drinks) and did not use any other substance, this would not be considered “chronic intoxication” in the PRISM.

If a subject passes screening for alcohol and/or drugs, the next step is to obtain a pattern of use. Determine if a subject experienced chronic intoxication and/or binge use for any substance ever in their life. Then, take a history of initial onset of chronic intoxication and/or binge use and any abstinent periods.

**Timelines**

The information gathered in the screening section is used to construct a timeline of substance use. Two timeline pages are provided in the PRISM for this purpose; one covers lifetime use, and the other covers the 12 months prior to the date of the interview. These two charts are provided to document patterns of use for alcohol and each of the nine drug classes. The timeline information is very important and will be used in later sections when a differentiation is made between substance-induced and primary mental disorders.

**Appendix A**

Appendix A of the PRISM 6.0 is a substance equivalencies chart. Commonly reported amounts of alcohol, cocaine, cannabis, and heroin, are converted to their equivalents for coding. The equivalencies chart will assist in the coding of #1b in the Substance Screening section (i.e. “Did you ever have 5 or more drinks of beer, wine, or liquor in a single day?”). For example, if a subject reports drinking a pint of liquor every day, the chart indicates the subject drinks the equivalent of 10 drinks each day.

**Appendix B**

Appendix B of the PRISM 6.0 is a list of the drugs within the nine drug categories. This drug list is handed to the subject during the Substance Screening section. It is important to give the subject time to look over the list. This is particularly true for subjects who have used multiple drugs to obtain similar effects. If the subject has reading difficulty, review each drug category by listing several drugs within each group.
Appendix C

Appendix C of the PRISM 6.0 is a Summary of Substance Use for Symptom Inquiry. This reference list is used when assessing the presence of symptoms for each substance the subject used in both the last 12 months and prior.

Special Attention

When charting the timeline, time spent in jail or in the hospital is considered an abstinent period unless the subject indicates otherwise. Clarify this with the subject as needed.

Q1a – If the subject has not had a drink at least 6 times in one year, Q 1b is skipped.

Q2 – If one of the boxes is checked for a substance in either time frame, ask about the presence of abuse and dependence symptoms (Section 3) regardless of whether or not the subject reports periods of chronic intoxication or binge use. A subject may meet some of the criteria for abuse or dependence when substances are used at a less than chronic level.
Purpose

Section 3 (PRISM, pgs.12-34) is designed to evaluate the four symptoms of DSM-IV Substance Abuse and seven symptoms of Substance Dependence, and to collect information regarding the course of these disorders. The criteria for Substance Abuse and Dependence are found on pages 181-183 of the DSM-IV.

The two aims of Section 3 of the PRISM are:

1. To identify the presence of substance abuse, current and past episodes;
2. To identify the presence of substance dependence, current and past episodes.

Main Elements

In DSM-IV, the diagnosis of Abuse is preempted by the diagnosis of Dependence. In the PRISM, however, a subject is assessed for Abuse and Dependence independently.

Substance Abuse

A diagnosis of substance abuse requires at least one of a group of four symptoms, including recurrent substance use despite failure to fulfill obligations, continued substance use despite persistent social/interpersonal problems, recurrent legal problems related to substance use, and recurrent substance use when it is physically hazardous.

Substance Dependence

A diagnosis of substance dependence requires at least three of a group of seven symptoms, including (but not limited to) tolerance, withdrawal, and unsuccessful efforts to cut down or control substance use. At least three symptoms must co-occur within a 12-month period.

Structure

Section 3 is comprised of two sub-sections: Substance Abuse, and Substance Dependence.

Symptoms

After the screening questions and Timeline construction are completed in Section 2, Section 3 assesses symptoms of Abuse and Dependence. Probe guidelines are found at the top of every page.
of symptoms (e.g., see PRISM, p. 12). These guidelines are provided to assist in covering a lot of ground (i.e., 10 drug categories in 2 time frames) and to help the interview flow easily. Assess each symptom for every substance before moving on to the next symptom.

There are four abuse symptoms and seven dependence symptoms. The questions related to a single symptom are contained within each of the large boxes. Boxes 1-4 (PRISM, pp. 12-15) correspond to the four symptoms of Criterion A for Substance Abuse. Boxes 5-11 (PRISM, pp. 21-28) include the seven symptoms comprising the criteria for Alcohol Dependence.

There are two columns for coding symptoms pertaining to use during two different time frames – the last 12 months and prior to the last 12 months. If the subject experienced the symptom in the last 12 months, code the response in the ‘Last 12 months’ column. If the subject experienced the symptom prior to the last 12 months, code the response in the “Prior to the Last 12 months’ column.

**Course of Abuse**

Note that only one symptom is necessary for a diagnosis of Abuse. If any symptom is coded in the ‘Last 12 months’ column, the offset must be within the last 12 months. This indicates the subject receives a “current” diagnosis of abuse. If no symptoms are coded for the last 12 months, offset must be more than 12 months ago for a “past” diagnosis.

**Course of Dependence**

Onset of initial Dependence episode refers to the first time 3 or more symptoms co-occurred within a one-year period. Q62a assesses the presence of 3 or more dependence symptoms within one year in the last 12 months, and prior to the last 12 months. Course questions to follow refer to this item to verify the presence of substance dependence.

Remission probes inquire about remissions that last at least one year.

Recurrence of dependence probes assess whether, after a period of remission, there was a time when the subject experienced 3 co-occurring symptoms again.

The PRISM obtains the offset of an episode of Dependence (i.e., three or more co-occurring symptoms) and the offset of any dependence symptom (see Qs 67-68). Remember that three or more symptoms must be coded in the “Last 12 months” column to receive a current Dependence diagnosis. If three or more symptoms are coded for the last 12 months, the offset must be within the last 12 months.

**Special Attention**

Check Items 3.14-3.23 – If a subject meets Dependence criteria for any substance, (i.e., when 3+ symptoms occurred during the same time frame) course questions must be asked.

Q60a and 60b – If the subject denies chronic intoxication or binge use in Substance Screening (Section 2), withdrawal symptoms must be coded “1” for that substance. See Interviewer Instruction (PRISM, p. 26).
Purpose

Interviewers unfamiliar with the criteria for Major Depression should read pages 320-327, and 339-345, of the DSM-IV. A DSM-IV diagnosis of Major Depressive Episode requires the presence of depressed mood or anhedonia most of the day, nearly every day for at least two weeks.

The three aims of Section 4 of the PRISM are:

1. To identify the presence of episodes of Major Depressive Disorder during the subject’s lifetime;
2. To assess current and past episodes of Primary Major Depression and Substance-Induced Major Depression;
3. To differentiate depressive symptoms from the expected effects of intoxication and/or withdrawal from substances.

Main Elements

To achieve the aims of this section of the PRISM, it is important to keep in mind the key concepts presented earlier in this manual: Primary Major Depression, Substance-Induced Major Depression, and the expected effects of intoxication and withdrawal.

Types of Depressive Episodes

Primary Major Depression (PMD) – At least a significant portion of a primary episode must occur when a subject is not using substances at all, or not enough to cause intoxication or withdrawal from a substance. Primary Major Depression can potentially be diagnosed in the following situations:

- A period of depression lasting at least two weeks during abstinence or occasional use, unrelated to medications or toxins;
• A period of depression beginning at least two weeks prior to a period of chronic intoxication or binge use;

• A period of depression that begins during substance use and clearly continues for at least four weeks after substance use has ended.
Substance-Induced Major Depression (SIMD) – A period of depressed mood can potentially be diagnosed as substance-induced under the following circumstances:

- The entire depressive episode co-occurred with chronic intoxication, binge use, or withdrawal;

- Chronic intoxication/binge use began less than 2 weeks after the onset of depression and the depression remitted during chronic intoxication, binge use, or withdrawal (within 4 weeks after cessation of substance use).
Expected Intoxication or Withdrawal Effects Due to Change in Use

The expected effects of intoxication or withdrawal are the predicted physiological effects of substance abuse and dependence. These effects are reflected in the substance-specific symptoms of intoxication and withdrawal syndromes for each of the main categories of substances (e.g., amphetamines, hallucinogens). See DSM-IV (pp. 183-272) for symptoms of these syndromes for each substance category. These symptoms mimic depressive symptoms in some instances.

When a depressive symptom is endorsed by a subject during a period of chronic intoxication or binge use, it must be determined whether the symptom was an expected effect of substance use or whether the symptom was a substance-induced depressive symptom. Ask the subject whether the symptom occurred during the time they were using substances, but before they became depressed (e.g., “Did you have insomnia when you were drinking before you got depressed?”). If the subject did not experience insomnia before the depressed mood started, the insomnia is coded “3”.

Additional points to remember:

- To differentiate substance-induced depressive symptoms from expected effects of intoxication and/or withdrawal, probes focus on significant changes (i.e., increases; decreases) in substance use co-occurring with the worst period of depressed mood.
• When the depressive episode is within one month following a significant change in use, symptoms will be considered the expected effects of intoxication or withdrawal (rather than depressive symptoms). In this case, symptoms will be coded “4.”

![Fig. 6: Insomnia co-occurring with change in use (intoxication/withdrawal)](image)

- Depressive symptom (e.g. insomnia)
- Steady-state use

• When the depression persists more than 4 weeks after a marked change in use, symptoms are considered substance-induced depressive symptoms and are coded “3.” All symptoms coded “3” are counted towards a Major Depression diagnosis.

• Note that some depressive symptoms cannot be considered the expected effects of intoxication or withdrawal, even if they occur within one month after a change in use or during a period of steady use (e.g., depressed mood, anhedonia, suicidality, guilt, indecisiveness).

• If the subject was depressed during a period of steady state use, and the symptom was present before the depression began and continued unchanged during the period of depression, the symptom is considered the expected effects of intoxication/withdrawal and coded “4.”

![Fig. 7: Insomnia present prior to depressed mood (intoxication/withdrawal)](image)

- Depressed mood
- Depressive symptom (e.g. insomnia)
- Steady-state use
If the subject reports a period of depression occurring during steady state use, symptoms are assessed based on the subject’s non-depressed, substance-using baseline. That is, if the subject reported insomnia before the depression began, did the insomnia get worse after the depression began? If the severity of the insomnia did not increase with the onset of depression, the insomnia is attributed to substance intoxication or withdrawal and coded “4”. If it became more severe after onset of the depression, it is attributed to Depression and coded “3”.

Appendix D

Appendix D is a guideline for symptom coding for Sections 4A and 4C to be used during the interview. Item #1 provides instructions on coding when the subject reports a significant change in substance use within the month prior to the onset of depression (PRISM, Q 15, p. 38, or Q 19, p. 78). If the subject experienced the symptom at the required level of severity and frequency, code “4”.

Item #2 provides instructions on coding when the subject reports steady state use prior to and during the entire period of depression. In this case, you compare the symptom after the onset of depression to the non-depressed substance-using baseline. If the symptom did not get worse after the depression started, the symptom is coded “4”. If the symptom worsened when the subject became depressed, it is coded “3”.

Structure

Section 4 (PRISM pp. 35-92) contains three subsections:

**Section 4A** screens for and assesses the most recent period of either primary or substance-induced depressed mood, including, but not limited to, the 2 weeks prior to the interview (pp. 35-53).

**Section 4B** screens for and assesses the worst prior primary major depressive episodes (pp. 54-72).

**Section 4C** screens for and assesses the worst prior substance-induced major depressive episodes (pp. 73-92).

Section 4A: Most Recent Depression

Section 4A covers the most recent episode of depressed mood, including the presence of depression in the two weeks prior to the interview.

If a subject passes screening but does not meet full criteria for either PMD or SIMD in Section 4A, the interview will skip you to Sections 4B and 4C.

Worst Part of the Most Recent Period

After establishing the beginning of the most recent period of depression, the subject is asked to determine when the worst part of that most recent period occurred. “Worst” is defined by severity of mood (or anhedonia) regardless of external circumstances or level of impairment. Correct identification of the “Worst Period” is very important because this is the period that will be the focus for symptom inquiry.
The middle column of Q16 provides guidelines regarding how to focus on a “worst” part. If a current depression occurred during a period that included both abstinence and substance use, consider “worst” only for the abstinent period of that depressive episode. If a subject reports that the worst part of his most recent depression occurred immediately after he resumed drinking, then ask him to select another time, if possible. This will allow a time to be evaluated when depressive symptoms are less likely to be the expected effects of intoxication or withdrawal.

Conversely, if a current depression is substance-induced and includes a change in use, consider “worst” only for the steady-state part of the depressed mood (and NOT the time when substance use changed). For example, if a subject has been drinking 6 beers every day, but reports the worst period of his depression coincided with a marked decrease in his drinking, then ask him to select a time during the same episode, other than this change in his drinking behavior. This will increase the chances of identifying depression symptoms that are not the expected effects of withdrawal.

Symptom Coding Options

As in the substance use disorders section, symptoms are presented in boxes (see PRISM, Qs 17-39, pp. 40-49). If the subject has five (or more) of the nine symptoms occurring at threshold (coded “3”) in the same two-week period, Criterion A of the DSM-IV diagnosis is met.

Symptoms are coded in two columns in Section 4A. If the worst part (of the most recent depressive episode) occurred in the last 2 weeks, symptoms in boxes 1A-9A are coded the same in Column I and Column II. However, if the worst part did not occur in the last 2 weeks, symptoms in boxes 1A-9A are coded separately in Column I and Column II.

There are four coding options for Depression symptoms:

“1” the subject did not experience the symptom;

“2” the symptom was experienced at a subthreshold level of severity, frequency, persistence or duration;

“3” the symptom fulfills all criteria listed in the middle column; and, the symptom is not attributed to intoxication and/or withdrawal;

“4” the symptom fulfills all criteria listed in the middle column but is attributed to the expected effects of intoxication and/or withdrawal. Only intoxication or withdrawal from the substances listed in the middle column of the symptom are ‘relevant’ because only their effects can cause the symptom being assessed.

A symptom is coded “4” under two conditions:

1. The symptom meets full symptom criteria as indicated in the middle column, and was present only during the month following an increase or decrease in substance use.

2. The subject became depressed during a period of steady state use, the symptom was present before the depression began, and continued unchanged during the period of depression.

Remember that symptoms coded “4” are not counted towards a diagnosis of PMD or SIMD.
Medical Condition during Depression

Sometimes, depressive symptoms are caused by an illness or medical condition (e.g., brain tumor, stroke).

Since the relationship of medical conditions and physical illness to depression continues to be an evolving area of research, this rule-out must be decided for your particular study. We recommend establishing a “policy” for your study to justify a decision that the general medical condition is etiological. In those studies in which it is particularly important to screen out possible etiological general medical conditions, it may make sense to establish a very low threshold (i.e., any possible associated general medical condition would result in the individual being screened out).

Impairment/Distress

When symptom criteria for depression have been met, the subject is assessed for impairment and/or distress in occupational or social functioning. Impairment or marked distress is required to receive a diagnosis. This criterion is met when a subject reports moderate or severe impairment/distress (coded “3” or “4”).

Special Attention

Q9 – If the subject reports 1+ month of abstinence or occasional use during most recent depression, check either the abstinence or occasional use box.

Q20-33 – Remember to consider “relevant substances” when probing for the presence of symptoms in Boxes 3A-8A. Refer to the middle column.

Section 4B: Prior Primary Major Depression (PMD)

If a SIMD was diagnosed in Section 4A, continue with Section 4B. This section covers potential Primary Major Depression (PMD). After a subject passes screening for depressed mood or anhedonia, the focus in this section is on a period that occurred prior to the period explored in Section 4A. Note that if the subject had more than one episode of depression in the past, the goal is to identify a period of PMD, preferably unrelated to the loss of a loved one or to a medical condition.

The structure of Section 4B differs significantly from the structure of Section 4A in the symptom coding options. Because the focus is on determining the presence of a potential primary episode in this section, symptoms co-occurring with heavy use should not be evaluated in this section. Therefore no “4” code is provided in the symptom boxes. Refer to the beginning of this section of the manual for clarification on the different types of depressive episodes.

If the period investigated in Section 4B turns out to be due to a medical condition or bereavement, Qs 4-13 (PRISM, pp. 55-57) are asked again to identify a primary depressive episode unrelated to these conditions.
Special Attention

Q4-8 – If the subject reports 1+ month of abstinence or occasional use during most recent depression, check either the abstinence or occasional use box.

Check Item 4B.16 – If a SIMD was not diagnosed in Section 4A, proceed to Section 4C.

Section 4C: Prior Substance-Induced Major Depression (SIMD)

If a PMD was diagnosed in Section 4A, this section will be completed. In Section 4C, inquire about potential Substance-Induced Major Depressive episodes.

The focus in this section is a period of depressed mood, co-occurring with heavy substance use, that occurred prior to the period explored in Section 4A. The symptom questions, impairment and distress questions, and Bereavement questions in Section 4C are identical to the questions in 4A.
Purpose

Criteria for Dysthymic Disorder are found on pages 345-349 of the DSM-IV. A DSM-IV diagnosis of Dysthymia requires the presence of depressed mood, more days than not, for at least two years without a remission of two months’ duration.

The two aims of Section 5 of the PRISM are:

1. To identify a period of 2+ years of low mood (intermittent or more persistent) and to assess whether full criteria for dysthymia for that period have been met;
2. To differentiate between a primary dysthymia and a substance-induced dysthymia.

Main Elements

Primary Dysthymia – An episode of low mood (lasting at least 2 years) is considered primary when the subject reports abstinence or only occasional use of alcohol and/or drugs for most of the time during the low mood.

Substance-Induced Dysthymia – If the subject reports chronic intoxication or binge use of a relevant substance, or a relevant medication, or exposure to a toxin for a significant portion of the period of low mood, the episode is considered substance-induced.

Structure

In PRISM Section 5 (PRISM, pp.95-100) only one 2-year period of low mood – the most recent period – is assessed.

Screening

Q1 assesses the presence of a 2-year period of low mood prior to the date of onset of a Major Depressive Episode (PMD or SIMD) coded in Section 4A.

If the subject did not meet full criteria for Depression in Section 4A, or if the Depression identified in Section 4A has fully remitted, you will skip to Q2 and inquire about a period of low mood lasting at least two years in a lifetime.
You will code the onset of the most recent episode of low mood in Q3. Note that the onset of Dysthymia must follow a period of normal mood lasting at least 2 months.

Differentiating Dysthymia from Major Depression

A key task in this section is to differentiate dysthyemic disorder from a major depressive episode. If a subject was diagnosed with a major depression, either primary or substance-induced, currently or in the past, it is important to determine the time of onset and remission.

Questions 4a-4c assist in this task:

- **Q4a** refers to Section 4A, the most recent major depressive episode. If a subject was diagnosed in this section, onset of dysthymia must be 2(+) years before the major depressive episode OR after full remission from the major depressive episode.
- **Q4b** refers to Section 4B, prior PMD episodes. If a subject was diagnosed in this section, onset of dysthymia must be 2(+) years before the PMD OR after full remission from the PMD.
- **Q4c** refers to Section 4C, prior SIMD episodes. If a subject was diagnosed in this section, onset of dysthymia, must be 2(+) years before the SIMD OR after full remission from the SIMD.

The middle column of 4a-4c refers to the pages and questions relevant to the dates of onset and remission for Sections 4A-4C.

Symptoms

Criterion B for a diagnosis of Dysthymia requires the presence, while depressed, of two or more symptoms (including poor appetite, insomnia, fatigue, low self-esteem, poor concentration or difficulty making decisions, feelings of hopelessness). Questions 6a-6f inquire about Dysthymic symptoms. Since this disorder usually persists for long periods of time, it is important to assess whether each symptom has co-occurred with depressed mood, and whether the symptom represents a distinct change from the subject’s usual self/behavior.

Differentiating Primary Dysthymia from Substance-Induced Dysthymia

To receive a diagnosis of Substance-Induced Dysthymia, the subject must have been drinking or using drugs most of the time during the two years of low mood. If the subject reports using drugs or drinking occasionally (less than 4 days a week/less than 4 drinks daily), the dysthymia is diagnosed Primary.

Alternatively, if the subject used drugs or drank alcohol chronically, OR, if the subject was taking medication prescribed by a doctor, or was exposed to a toxin, any of which caused their low mood, the diagnosis is Substance-Induced Dysthymia.

Medical Condition during Dysthymia

Much like the relationship between depression and physical illness or medical conditions, the relationship of medical conditions and physical illness to dysthymia must be ruled out in a consistent fashion. Setting a policy to handle these cases in your study is relevant to the diagnosis of Dysthymia as well as Major Depression.
Purpose

Sections 6 and 7 in the PRISM evaluate the symptoms of Mania, Hypomania, and Cyclothymia.

Interviewers unfamiliar with the criteria for a Manic Episode and a Hypomanic Episode should read pages 332 and 338 of the DSM-IV. Criteria for Cyclothymic Disorder can be found on pages 365-366 of the DSM-IV. A DSM-IV diagnosis of Mania requires the presence of a period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least one week with accompanying symptoms (e.g., flight of ideas; decreased need for sleep). Hypomania requires the same mood and symptoms, but may be shorter in duration (i.e., lasting at least 4 days and is never severe enough to cause marked impairment, to necessitate hospitalization, and there are no psychotic features). Cyclothymia, like Dysthymia, requires a 2+ year period of alternating moods, and is a much more rare disorder.

The three aims of Sections 6 and 7 of the PRISM are:

1. To identify a period of elevated, expansive, or irritable mood lasting at least 4 days to at least one week in duration, and to assess whether full criteria for a manic or hypomanic episode have been met;
2. To differentiate between a primary manic episode and a substance-induced manic episode (or a primary hypomanic episode and a substance-induced hypomanic episode);
3. To identify a period of 2+ years of alternating hypomanic and depressed mood, for more days than not, for at least two years without a remission of two months’ duration.

Section 6 – Mania and Hypomania

As in the Depression section, screen for the disorders at the beginning of the section, identify a potential episode, differentiate primary from substance-induced episodes, ask symptom questions, and assess marked impairment and/or distress.

Main Elements

To differentiate Mania and Hypomania from substance-induced manic and hypomanic episodes, it is important to understand the four key concepts in this section:

Primary Manic Episode – A primary manic episode may be diagnosed when a period of elevated or irritable mood persists for at least one week (or less, if hospitalization is required) unrelated to substances or medication.
Primary Hypomanic Episode – A primary hypomanic episode may be diagnosed when a period of elevated or irritable mood that is clearly different from usual mood lasts at least 4 days unrelated to substances or medication, but is not severe enough to cause marked impairment or necessitate hospitalization.

Substance-Induced Manic Episode – An elevated or irritable mood is identified as substance-induced when the mood co-occurs with cocaine, stimulants, or PCP intoxication; OR, it remits within 4 weeks after cessation of cocaine, stimulant, or PCP use (withdrawal). The elevated or irritable mood must be greater than the expected effects of cocaine, stimulant, or PCP intoxication. See the middle column for coding guidelines. High mood that begins within one month of taking prescribed antidepressant medication and remits within one month after cessation of use is also considered substance-induced.

Substance-Induced Hypomanic Episode – The criteria are the same as a substance-induced manic episode. However, the mood disorder is characterized by unequivocal change as opposed to impairment and does not require hospitalization.

Structure

Choosing a worst period

When choosing a worst period of abnormal and persistently elevated mood, a potential primary episode takes precedence over a substance-induced episode. Questions 5-15 (PRISM, pp. 136-138) provide probes to rule out periods of elevated mood related to cocaine and other stimulants, and to anti-depressant medication.

Section 7 - Cyclothymia Main Elements

Primary Cyclothymia – A diagnosis of cyclothymia requires at least 2 continuous years of alternating hypomanic and depressed mood unrelated to substance use. There must not be a remission of symptoms for 2+ months during this time. If a major depressive episode or manic episode was diagnosed during these 2 years, a diagnosis of cyclothymia is ruled out.

Substance-Induced Cyclothymia – If the cyclothymic disorder occurred entirely during a period of chronic intoxication and withdrawal from alcohol, cocaine, heroin, hallucinogens, sedatives, stimulants, opiates, or methadone, the disorder is considered “substance-induced.”

Structure

This section follows a similar structure to the other mood disorder sections (i.e., screening, symptoms, course questions).

One important rule-out is the presence of physical illness during the whole period of mood changes. Like the other mood disorders, it is critical to inquire whether a doctor ever said mood changes are caused by a relevant illness (e.g., Cushing’s or Addison’s diseases, Parkinson’s disease, Multiple Sclerosis). The middle column provides a list of illnesses “relevant” to mood change. The presence of physical illness during the entire 2-year period of cyclothymia is very rare, as is Cyclothymia in general. When in doubt, code this relationship “1,” indicating physical illness is NOT the cause of mood disturbances.
Purpose

Section 8 (PRISM, pp.154-180.9) consists of three sections—8A, 8B, and 8C—which assess the symptoms and features associated with psychotic disorders.

Interviewers unfamiliar with the criteria for psychotic disorders should read pages 273 - 315 of the DSM–IV.

The four aims of Section 8 of the PRISM are:

1. To identify the presence of psychotic episodes during lifetime;
2. To differentiate among types of psychotic disorders;
3. To differentiate psychotic symptoms from the expected effects of intoxication and/or withdrawal;
4. To differentiate primary from substance-induced psychosis.

Main Elements

**Primary Psychotic Disorder** – A primary psychotic disorder can be diagnosed in the following cases:

- An active phase or non-bizarre delusions that begin during abstinence or occasional use and continue at least one month during abstinence or occasional use (unrelated to physical illness, medications, or toxins);
- A period of an active phase or non-bizarre delusions that begin during intoxication and continue at least one month after heavy substance use has ended;
- A brief psychotic episode (lasting one day to one month) that a) begins during abstinence or occasional use and b) begins at least one month after heavy substance use has ended.

**Substance-Induced Psychotic Disorder** – A period of psychotic symptoms is considered substance-induced under the following circumstances:

- The entire psychotic episode co-occurred with chronic intoxication, binge use, or withdrawal of a ‘relevant substance’ (‘relevant substances’ are specified in the middle column).
Chronic intoxication began less than a months after onset of an active phase or non-bizarre delusions;

A brief psychotic episode begins during intoxication or withdrawal.

Expected Intoxication or Withdrawal Effects

The only type of psychotic symptoms that can be considered (under certain circumstances) as the expected intoxication or withdrawal effects are hallucinations. When hallucinations occur during a period of intoxication and the person experiencing the hallucinations is aware that the symptom is caused by substance use (at the time the symptom occurs) and does not act in response to the symptom—the symptom is considered to the effect of alcohol or drug use, and NOT a symptom of a psychotic disorder. In this case the hallucination is coded “4”.

Structure

In Section 8, assess the presence of a psychotic disorder during a subject’s lifetime. In the PRISM, a psychotic episode may meet DSM-IV criteria for any of the following disorders:

- Schizophrenia
- Schizophreniform Disorder
- Schizoaffective Disorder
- Delusional Disorder
- Brief Psychotic Disorder.

Only one of these diagnoses can be given in Section 8.

If a psychotic episode does not meet full criteria for any of the psychotic disorders noted above, one of the following disorders may also be diagnosed:

- Psychotic Disorder Due to a Medical Condition
- Psychotic Disorder NOS
- Mood Disorder with Psychotic Features.

Section 8A

In Section 8A, the presence of psychotic symptoms in the subject’s lifetime is investigated. If the subject denies having psychotic symptoms, skip to Section 9.

Once the subject reports one (or more) psychotic symptom(s), the presence of a primary active phase is investigated (PRISM, Qs 17-23, pp. 160-162). Subjects who never had a primary active phase are skipped to section 8B. The remainder of Section 8A assesses whether criteria for Schizophrenia, Schizophreniform, or Schizoaffective Disorder are met (including the course of the illness). Note that Psychotic Disorder NOS is diagnosed when the subject denies impairment or impairment is “mild” (coded “1” or “2”).
Section 8B

In Section 8B, the presence of a primary Delusional Disorder (PRISM, Q 1-18, pp. 171-173), and a primary Brief Psychotic Disorder (PRISM, Q 19-32, pp. 176-179), is investigated.

If full criteria are not met for either disorder, a Psychotic Disorder NOS can be diagnosed. The conditions under which Psychotic Disorder NOS is diagnosed are:

- Subject had delusions for 1+ month, and impairment is moderate or severe (Q 16 is coded “3” or “4”);

or

- Psychotic symptoms lasted less than one day (i.e. less than 24 hours) or more than one month (Q 19);

or

- A brief psychotic episode has not yet remitted for 2+ months (Q 30).

Section 8C

In Section 8C the presence of a substance-induced psychotic disorder is investigated.

Section 8C is divided into 3 parts. Complete only one of these three parts in your interview with the subject.

In the first part, (Qs 1-23), criteria for substance-induced schizophrenia, substance-induced schizophreniform disorder, and substance-induced schizoaffective disorder are assessed.

In the second part, (Qs 24-32), substance-induced delusional disorder is investigated.

In the third part, (Qs 33-39), substance-induced brief psychotic disorder is assessed.

Section 8A

Section 8A begins with positive and negative psychotic symptom probes. On the top of each page, interviewer instructions are provided to aid in the coding of symptoms. Additional probes are often required to determine the severity and persistence of the symptom. Coding guidelines provide specific criteria for determining whether or not the subject’s response meets the required threshold.

If a symptom is coded “3,” mark Appendix E, which can be found in the back of the PRISM. The Unusual Experiences appendix is designed to help you organize information in the Psychosis section.

Coding Options for Hallucinations

There are four coding options for hallucinations:

- “1” the subject did not experience that type of hallucination;
“2” the hallucination was experienced at a sub-threshold level of severity, persistence, or duration;
“3” the hallucination was vivid, persisted for at least 1 hour, was abnormal for subject’s culture, or the subject acted on the hallucination;
“4” the hallucination fulfills all criteria required for a “3” code but the subject was aware that the symptom was induced by alcohol or drug use at the time the symptom occurred. Also, the subject did not act in response to the symptom. Code “4” indicates that the symptom is an effect of alcohol or drug use, and NOT a symptom of a psychotic disorder.

Small Boxes

Almost all of the items for psychotic symptoms require a numerical code (i.e., “1,” “2,” or “3”) plus a small check box for specification. For example, Qs 1-6 (pp. 154-155 assessing delusions have a small box labeled “Bizarre Delusions.” If one of these questions is coded “3,” and the delusion is bizarre, check the small box next to the question.

Disorganized Speech and Behavior

Questions 14-15 (p. 159) are designed to determine the presence of disorganized speech and grossly disorganized or catatonic behavior. While positive symptoms may be induced by a substance, it is not as likely to be the case with these behaviors.

The middle column of each question instructs you to make a coding decision based on the presence or absence of substance use, physical illness, or medication effects. The symptom is not coded “3” if it is caused by any of these factors.

Negative Symptoms: Avolition, Alogia, Affective Flattening

Question 16 (p. 159) is designed to determine the presence of negative symptoms - avolition, alogia, or affective flattening. These questions are not coded “3” if entirely related to substance use, physical illness, or depressed mood. Small boxes are provided under the coding options so you can specify which negative symptoms are being coded.

Observable Symptoms

Disorganized speech, disorganized/catatonic behavior, and affective flattening observed during the course of the interview should be coded “3” even if the subject denies the symptom. However, only symptoms that depart markedly from the norm for speech, behavior, and expression should be coded “3”.

Course of Schizophrenia

Questions 40-46 (pp. 166-167) establish the course of Schizophrenia, focusing on the prodromal and residual phases. Assess the weeks or months before and after the active phase coded in this section.

Some of the symptoms of a prodromal phase are social isolation, poor hygiene, and a lack of interest. If the subject reports having had these experiences, code “3” for Q 40 and check all
the boxes that apply (e.g., social isolation, poor hygiene). Question 41 asks for the best estimate of when these symptoms began (i.e., age of onset, or months ago).

Some subjects will report the experience of residual symptoms. These symptoms are parallel to those of a prodromal phase (e.g., social isolation, poor hygiene). Question 42 assesses the presence and type of residual symptoms the subject experienced.

Question 43 assesses remission. If the subject currently experiences residual symptoms, code “1 day ago.” That is, the subject receives a current Schizophrenia diagnosis. If residual symptoms remitted 2 or more months ago, the diagnosis is past Schizophrenia.

If the total disturbance (including prodromal, active and residual phases) is less than 6 months, Schizophreniform Disorder is diagnosed.

Co-Occurrence of Mood Symptoms and Psychotic Symptoms

The final questions of Section 8A differentiate Mood Disorder with Psychotic Features and Schizoaffective Disorder. In cases where mood symptoms co-occurred with psychotic symptoms, Q 47 (p. 168) is coded “3” and all the boxes that apply are checked (“depression”, “mania”, or “mixed”).

If the subject reports having had a Major Depression or a Manic Episode for more than 50% of the total duration of the psychotic disturbance, Q 48 (p. 168) is coded “3”.

If the subject EVER experienced active phase symptoms of psychosis in the absence of prominent mood symptoms, Q 49 (p. 168) will be coded “3.” This answer will result in a diagnosis of Schizoaffective Disorder. If Q 49 is coded “1” (i.e., psychotic symptoms always occurred with a mood episode), the diagnosis is Mood Disorder with Psychotic Features.

Medical Condition during Active Phase

Sometimes, psychotic symptoms are caused by an illness or medical condition (e.g., brain tumor, stoke). Questions 27-29 (p. 163) and 36-37 (pp. 165-166) assess the co-occurrence of active phase symptoms and medical conditions.

If an active phase is due to a relevant medical condition, the Interviewer Instructions (p. 163) instruct you to probe for an active phase in the absence of a medical condition (Qs 30-35). It is important to remember that the medical condition must be shown to directly cause the disturbance. Like the mood disorders, it is critical to inquire whether a doctor ever said mood changes are caused by a medical condition or illness (e.g., heart surgery). Since the relationship of medical conditions and physical illness to psychosis continues to be an evolving area of research, this rule-out must be decided on a study-by-study basis.

Special Attention

Q8 – If the small box is checked for bizarre delusions in Qs 1-6, this item must be coded “yes.”
Section 8B

If the subject reported psychotic symptoms in Section 8A, but never experienced an active phase of psychosis, skip to Section 8B.

Non-Bizarre Delusions

The presence of non-bizarre delusions is assessed at the beginning of this section. Your first task is to determine the presence of non-bizarre delusions for one month or more (DSM-IV Criterion A for Delusional Disorder).

If the subject denies non-bizarre delusions lasting at least one month, skip to Q 19 (PRISM, p. 176). Here, ask about the presence of any other psychotic symptom lasting from one day up to one month. Remember that the symptom must be present at least one full day, which is defined as a 24 hour period (see Q 19, middle column), in order to code “3”. Small boxes are provided to indicate all the symptoms that apply.

Substances and Other Causal Factors

If the subject reports non-bizarre delusions for at least one month, determine if the non-bizarre delusion is primary or related to substance use. Questions 2, 3, and 4 (p. 171-172), assess abstinence or occasional use for at least one full month during the delusional period. You will also determine the presence of medication use and exposure to toxins that may cause delusions (e.g., anti-hypertensive medications, steroids, gasoline, paint fumes). If delusions are not primary, skip to Question 19 and continue to inquire about the occurrence of a Brief Psychotic Episode.

If the subject has ever experienced a major depressive episode or a manic episode, screen for the co-occurrence of psychotic symptoms in Qs 10-11. When applicable, check the small boxes that specify the type of mood disorder (depression; mania; mixed episodes). If delusions always co-occurred with mood symptoms, the diagnosis is Psychotic Disorder NOS or Mood Disorder with Psychotic Features.

Special Attention

Q1a – Other episodes/delusions other than those reported in Section 8A are explored in this question.
Section 8C

If all psychotic symptoms assessed in Sections 8A and 8B are related to substance use, continue through Section 8C to determine the specific substance-induced diagnosis. The three Check Items at the top of Page 180 determine which part of Section 8C to follow.

Differential Diagnosis and Course

If the subject had a substance-induced active phase (as determined in Section 8A), code the onset of the substance-induced active phase in Qs 1-23 and determine the differential diagnosis. These questions parallel those in Section 8A.

If non-bizarre delusions are the only psychotic symptom reported by the subject, and these delusions are substance-induced, investigate the course of the illness in Qs 24-32 (pp. 180.6-180.8) (as in Section 8B).

If a brief psychotic episode is substance-induced, investigate the course of the illness in Qs 33-39 (pp. 180.8-180.9) (as in Section 8B).

As noted previously, only one part of Section 8C is coded. Once that part is completed, skip to Section 9.

Special Attention

Q13 – If the subject continues to be dependent upon social services, code “1 day ago.” This means residual symptoms are “current” and subject will receive a current diagnosis.

Q20 – Impairment must be coded “3” or “4” (“moderate” or “severe”) to meet threshold for certain diagnoses (see Check Item 8C.14A).
Purpose

Sections 9 through 15 (PRISM, pp.181-217) cover the Anxiety Disorders: Specific Phobia, Social Phobia, Panic Disorder, Agoraphobia, Generalized Anxiety Disorder, Obsessive Compulsive Disorder, and Posttraumatic Stress Disorder (PTSD). For criteria related to each of these disorders, read the DSM-IV chapters on Anxiety Disorders (pp. 393-444).

Studies have consistently demonstrated co-morbidity of anxiety disorders and alcohol use disorders. This is important to keep in mind when taking a subject with an extensive alcohol history through these sections.

The two aims of sections 9-15 of the PRISM are:

1. To identify the symptoms of anxiety and/or panic and to determine if the full criteria for an anxiety disorder are met;
2. To identify the presence of substance-induced panic disorder or substance-induced generalized anxiety disorder.

Main Elements

Only two substance-induced diagnoses are possible in these seven sections of the PRISM: Substance-Induced Panic Disorder, and Substance-Induced Generalized Anxiety Disorder.

Substance-Induced Panic Disorder – Panic Disorder is considered substance-induced when:

- A full syndrome Panic Disorder occurred during intoxication with relevant substances (i.e., caffeine, over-the-counter diet pills, cocaine, cannabis, hallucinogens, PCP, stimulants and/or inhalants;
- A full syndrome Panic Disorder occurred during acute withdrawal (4-week period) from relevant substances (i.e., alcohol, cocaine, sedatives).

Substance-Induced Generalized Anxiety Disorder – Generalized Anxiety Disorder is considered substance-induced under the following conditions:

- The entire anxiety disorder co-occurred with chronic intoxication with relevant substances (i.e., cocaine, stimulants, PCP, hallucinogens, cannabis, and inhalants);
- The anxiety began during the 4-week period of withdrawal from relevant substances (i.e., alcohol, cocaine, or sedatives) and did not persist for an additional six months after the withdrawal period.
Differences in Anxiety Disorders Sections

The phobia sections, Section 9 (Specific Phobias), Section 10 (Social Phobias), and Section 12 (Agoraphobia), include questions pertaining to the situations or objects feared and the consequences of the fears.

The somatic correlates of anxiety are covered in Section 11 (Panic Disorder) and Section 13 (Generalized Anxiety Disorder). Section 11 (Panic Disorder) and Section 13 (Generalized Anxiety Disorder) also include questions covering substances and other causal factors because these diagnoses require that symptoms be unrelated to the physiological effects of a substance or general medical condition.

Section 14 (Obsessive Compulsive Disorder) assesses repeated thoughts and behaviors, and the subject’s level of insight into the excessive or unreasonable qualities of these thoughts and behaviors.

Section 15 (PTSD) focuses on traumatic events in the subject’s history which may have an impact on functioning.

Section 9 - Specific Phobia

Type of Specific Phobia

Question 1 (p. 181) pertains to an intense and persistent, excessive or unreasonable fear of a specific object or situation. Fear of several types of situations and objects are inquired about including animals or bugs, flying in airplanes, and being in crowds or elevators.

If the subject reports a fear that is triggered by the anticipation or presence of a specific object or situation, code ‘3’ and check the appropriate box (e.g., animals). If the subject reports more than one thing or situation, ask the subject to choose the one thing/situation they fear MOST. Check only one box adjacent to the stimulus feared most by the subject. Then, continue questioning in this section focusing on this thing/situation.

Anxiety Response

If the subject almost always experiences an intense anxiety response when exposed to the feared object/situation, continue coding the section. If the subject does not almost invariably experience immediate, intense anxiety upon exposure to the feared object or situation, skip to Section 10. It is important to note that intense anxiety may be experienced as physical symptoms only, without conscious fear (see middle column).

Subject’s Opinion of the Fear

If the subject does not believe the fear is either unreasonable or excessive, skip to Section 10.
Special Attention

Q1 – Check the box adjacent to the stimulus feared most by the subject. Only one box should be checked.

Q6 – Interference must be considered moderate or severe by the subject in order to receive a diagnosis (see Check Item 9.1, p. 182). If interference is coded “1” or “2”, inquire about distress (Q7).

Section 10 - Social Phobia

Type of Situations

Question 1 (p. 184) assesses marked and persistent fear of social or performance situations (e.g., public speaking, meeting new people). If the subject reports a fear, code “3” and mark the appropriate box (e.g., speaking/performing). If the subject reports more than one fear, ask the subject to select the situation they are most afraid of, check the adjacent box, and proceed into the section.

Anxiety Response to Phobic Stimulus

If the subject almost always experiences an intense anxious response when exposed to the feared situation/activity, code “3” (Q 2). If the situation/activity is avoided, it is enough if the subject experienced intense anxiety in the past when exposed to the feared object/situation to code a “3”. It is important to note that intense anxiety may be experienced as physical symptoms only, without conscious fear (see middle column).

Subject’s Opinion of the Fear

If the subject does not recognize that the fear is unreasonable or excessive (Q 3), skip to Section 10.

Avoidance and Endurance

If the subject neither avoided the feared object (Q 4) or situation nor endured it with intense anxiety (Q 5), skip to Section 10.

Section 11 - Panic Disorder

Screening

Attacks need to be recurrent to meet Criterion A of the DSM-IV criteria, but it is of research interest to see if attacks meet a certain frequency threshold (Qs 1-3, p. 187). If the subject has never had 2 panic attacks, skip to section 12.

Worst or Most Recent Panic Attack

Identifying a specific panic attack is necessary so that the symptoms of a panic attack can be assessed in Qs 10a-m (pp. 188-189). In addition, this will assist in determining whether the
attacks are substance-induced or primary panic attacks.

In the PRISM, primary panic attacks take precedent over substance-induced panic attacks. If the subject experienced both primary and substance-induced panic attacks, it is important to focus on whichever was the worst unexpected panic attack that was unrelated to illness or use of a substance (see Q9).

**Persistent Concern and Behavior Change**

If the subject did not experience worry or behavior change for as long as one month following an unexpected, full panic attack (see Check Item 11.5, p. 190), skip to Section 12.

**Section 12 - Agoraphobia**

Like DSM-IV, the PRISM diagnoses Panic Disorder with Agoraphobia and Agoraphobia without history of Panic Disorder.

**Differential Diagnosis**

If fear of all situations is better accounted for by a diagnosis other than Agoraphobia (Q3: e.g., Posttraumatic Stress Disorder, Obsessive-Compulsive Disorder, Depression, Paranoia, Psychosis, or Generalized Anxiety Disorder), skip to Section 13.

**Avoidance and Endurance of Feared Situations and the Need for a Companion**

If the subject reports avoidance or endurance of feared situations despite intense anxiety (Q4), AND is unable to encounter the feared situation without a companion (Q5), diagnose potential Agoraphobia.

**Special Attention**

A fear of crowds or other social or specific situations that warranted a Social Phobia or Specific Phobia diagnosis should not be coded again in this section.

**Section 13 - Generalized Anxiety Disorder**

Generalized Anxiety Disorder requires that the subject experience unrealistic or excessive worry and anxiety for a minimum of six months in duration entirely apart from another psychiatric disorder (Q3: e.g., depression, dysthymia, mania, psychotic disorder).

**Selection of a Worst Episode**

After the subject screens into this section (see Q8), focus the subject on a specific period of time when the anxiety/worry was most severe.

**Special Attention**

The subject’s inability to control the worry despite frequent efforts to do so, which is criterion B of the DSM-IV definition of Generalized Anxiety Disorder, must be met for this diagnosis.
Section 14 – Obsessive Compulsive Disorder

Obsessive thinking must be persistent and recurrent, and must not simply be excessive worries about real-life problems. In addition, obsessive thoughts must not be exclusively related to another mental disturbance.

Compulsive behaviors must be persistent and recurrent, not pleasurable beyond the temporary relief of tension or anxiety, and aimed at reducing or preventing distress or preventing some dreaded event or situation.

Causal Factors

If symptoms are the direct effects of a general medical condition (Q 10: e.g., head injury, seizures), a diagnosis of Obsessive Compulsive Disorder cannot be made.

Subject's Opinion of Obsessions/Compulsions

If the subject does not recognize that the obsessions and/or compulsions are excessive or unreasonable at some point during the course of the disturbance (Q 11, p. 207), skip to Section 15.

Section 15 – Posttraumatic Stress Disorder

This section does not contain a general screening question. Instead, the section investigates the presence of traumatic events in a subject’s past, including military combat, sexual assault, and witnessing a serious injury or unnatural death in a subject’s history. If a subject acknowledges a traumatic experience, their responses are assessed. Presence of a trauma and response to trauma both address Criterion A – DSM-IV. If the subject experienced more than one traumatic event, they are asked to identify the worst one. Identification of a worst traumatic experience is necessary so that the symptoms of PTSD can be assessed in Qs 10-26 (pp. 212-215).

Symptoms

There are three groups of symptoms relevant to the diagnosis of PTSD: re-experiencing the trauma, avoidance or general numbing of responsiveness, and persistent increased arousal (Criteria B, C, and D – DSM-IV). The subject must experience a specified number of symptoms from each group in order to meet diagnostic criteria:

Re-experiencing the Trauma

The presence of recurrent and intrusive distressing recollections or dreams of the event, acting or feeling as if the event were recurring, intense psychological distress or physiological reactivity on exposure to internal or external cues reminiscent of the event are assessed in Qs 10-14 (pp. 212-213). The subject must report at least one of these.

Avoidance or General Numbing of Responsiveness

Efforts to avoid reminders, inability to recall, markedly diminished interest or participation, feelings of detachment or estrangement, restricted range of affect, and sense of a foreshortened future are assessed in Qs 15-21 (pp. 213-214). The subject must report at least three of these. In a structured interview, these symptoms may be the most difficult to elicit by self-report. Be sensitive and aware the subject may have difficulty identifying these experiences.
Persistent Increased Arousal

Difficulty sleeping, irritability, difficulty concentrating, hyper-vigilance, and exaggerated startle response are assessed in Qs 22-26 (pp. 214-215). The subject must report at least two of these.

Duration

The subject must experience symptoms from these three groups around the same time for at least one month (Q 27, p. 215).

Impairment/Distress

When symptom criteria for PTSD have been met, the subject is assessed for impairment and/or distress in occupational or social functioning. Impairment or marked distress is required to receive a diagnosis (see Check Item 15.6, p. 216). This criterion is met when a subject reports moderate or severe impairment/distress (coded “3” or “4”).

Special Attention

Q34 – A recurrence of PTSD requires the recurrence of the full syndrome, not one symptom (one nightmare or bad feelings about the trauma).
Purpose

Sections 16 and 17 (PRISM, pp. 218-220; 221-223) cover the two eating disorder diagnoses familiar to most clinicians, Anorexia Nervosa and Bulimia Nervosa. Criteria for these disorders are found on pages 539-550 of the DSM-IV.

The aim of sections 16-17 PRISM is:
To identify the presence of eating disorders, current and past episodes.

Structure - Section 16 - Anorexia

This section begins with questions about weight and height that provide general information, and also serve as initial screening questions for Anorexia (Qs 1-7, pp. 218-219). If the subject does not report a body weight 15% lower than expected for adult height, skip to section 17. A chart is provided (on p. 218) that indicates weights representing 15% below that expected for males and females.

The subject must also report a refusal to maintain a “minimally normal” weight, and report an intense fear of gaining weight or becoming fat. If the subject meets these criteria (Qs 5-6, p. 219), continue in this section.

Question 8 (p. 219) provides information about subtyping Anorexia (i.e., purging) if a subject engages in purging behavior, and refuses to maintain a healthy body weight.

Question 9 (p. 219) provides the final diagnostic criterion for Anorexia, loss of menstrual periods (Criterion D – DSM-IV). This criterion only applies to postmenarcheal females. This item should automatically be coded “3” for subjects who never established regular periods (monthly or near monthly).

Information on impairment is gathered in Q 10 (p. 220), although impaired functioning is not a requirement for the diagnosis.

Subjects who meet full criteria for Anorexia are asked course questions(Qs. 11-16, p. 220).
Section 17 begins with the screening question on binge eating, and a follow-up question on the DSM-IV frequency criterion (Q. 1, p. 231). Question 3 pertains to perceived loss of control. If a subject does not report a feeling of lack of control over eating behavior during the period of binges, skip to Section 18.

Questions 4a and 4b assess the presence of common types of compensatory behaviors (e.g., self-induced vomiting; laxatives; fasting; excessive exercise). These address Criterion B of the DSM-IV definition for Bulimia Nervosa.

Question 5 covers the required frequency of these behaviors, per DSM-IV criteria. If the subject does not meet this criteria, skip to Section 18.

Questions 6 and 7 cover additional DSM-IV criteria for Bulimia (self-evaluation unduly influenced by weight – Criterion D; bulimic periods occurring outside of episodes of Anorexia – Criterion E).

Subjects who meet criteria for Bulimia are asked course questions.
Purpose


The two aims of Sections 18 and 19 of the PRISM are:

1. To identify patterns of behavior that meet criteria for Borderline and/or Antisocial personality disorders;
2. To identify dysfunctional behaviors that are enduring throughout the subject’s lifetime.

Structure - Section 18 - Antisocial Personality Disorder

Conduct Disorder

A diagnosis of Antisocial Personality Disorder requires that the subject have a history of aggression, destruction of property, deceitfulness or theft, and/or serious violations of rules before age 15 - Criterion A of the diagnosis of Conduct Disorder. For this reason, Section 18 begins with questions about behaviors occurring before age 15. Note that repeated truancy (Q 1b, page 224) and staying out at night despite parental prohibition (Q2b, page 224) must occur before age 13 to be counted towards a diagnosis of childhood Conduct Disorder.

Questions 1-15 (pp. 224-226) cover behaviors associated with Criterion A of childhood Conduct Disorder (e.g., stealing; lying; cruelty to animals). Question 16 corresponds to social, academic, or occupational impairment caused by these behaviors (Criterion B of Conduct Disorder), and Q 17 pertains to the co-occurrence of three or more behaviors within a twelve-month period. The subject meets criteria if impairment is evident, and three behaviors occurred within the same year.

Relationship to Mania or Psychosis

Antisocial Personality Disorder should not be diagnosed if antisocial behavior occurs only during the course of schizophrenia or a manic episode. Subjects who have experienced episodes of Mania or psychosis must be asked to report experiences that happened when they weren’t manic or psychotic (see instruction below statement J.Z, p. 227). Code “1” if all occurrences of a behavior occurred exclusively during a Manic Episode or active phases of schizophrenia.
Time Frames

Personality Disorders are usually diagnosed as enduring over a lifetime. However, the PRISM provides a way to also assess whether symptoms occurred recently (i.e., over the last 12 months).

To diagnose Antisocial Personality Disorder, adult antisocial behaviors must be present since age 15 and continue throughout adulthood. Code the presence of antisocial behaviors in two time frames: column I refers to the past (enduring behaviors since age 15); column II refers to the last 12 months. The time frame “Since Age 15” was provided to establish a stable and enduring pattern of behaviors continuing throughout adolescence into adulthood.

For a diagnosis to be considered current and past, onset occurred in the past, full criteria have been met prior to the last 12 months, and one or more symptoms are present within the last 12 months.

Adult Antisocial Behaviors

Questions 18 - 24 (PRISM, pp. 227-230) cover behaviors that indicate adult personality traits that comprise Criterion A for Antisocial Personality Disorder. Repeated behaviors (e.g., lying) and/or consistently irresponsible behaviors (e.g., failure to pay child support) are assessed in this section.

Questions 18, 22 and 23 are subdivided, with each question covering a different behavioral expression of the corresponding trait. For example, questions 22a and 22b correspond to consistent irresponsibility. Each question covers a behavior that indicates this trait: unemployment, repeated absences from work, and failure to honor financial responsibilities. These behaviors are summarized in Q 22c. If the answer to any question 23a-23c is “yes,” then 23d must be coded “yes.”

Question 19 (irritability and aggressiveness) includes small boxes to check. These boxes indicate the presence of domestic violence in the home, and the extent of physical aggression (i.e., whether the subject caused injury to another person).

Extenuating Circumstances

Questions 1, 3, and 22 in Section 18 have small boxes below the coding options. Each small box is labeled with one or more extenuating circumstances that may have prompted the behavior in question. The “extenuating circumstances” boxes are provided because some undesirable behaviors could be considered adaptive responses in particular social and environmental contexts. If a behavior is enduring since age 15, code “3”, but check one or more of these boxes if all occurrences of the behavior happened under extenuating circumstances.

For example, Q 3 asks about running away from home. After coding the question according to the guidelines in the middle column, check the first small box, labeled “physical abuse,” only if all occurrences of running away from home were to avoid physical abuse. Space is provided under the middle columns of these questions to record the specifics of the extenuating circumstance.
Middle Column

As in early sections of the PRISM, the middle column of each question contains coding guidelines specific to the corresponding criterion. For example, the middle columns of questions 18-24 instruct you to code “1” for behaviors that occurred only during episodes of Mania or an active phase of Schizophrenia.

Special Attention

Q23d – If the answer to any of questions 23a-23c is “yes,” in either column I or II, then this item must be coded “yes.”

Check Item 18.4 – You are referred to Check Item 18.1 (‘Did subject potentially meet criteria?’). If the subject reported 3 or more symptoms of Conduct Disorder, a diagnosis of Antisocial Personality Disorder can be made even if the subject did not experience impairment related to the Conduct Disorder.

Structure - Section 19 - Borderline Personality Disorder

Diagnostic Features

Like Antisocial Personality Disorder, Borderline Personality Disorder is part of the cluster B dimension of the DSM-IV category of personality disorders. Individuals with these personality disorders often appear dramatic, emotional, or erratic.

According to DSM-IV, the essential feature of Borderline Personality Disorder is a pervasive pattern of instability of interpersonal relationships, self-image, affect, and marked impulsivity that begins by early adulthood and is present in a variety of contexts.

Time Frames

Personality Disorders are usually diagnosed as enduring over a lifetime. However, as is the case for Antisocial Personality Disorder, the PRISM provides a way to also assess whether symptoms of Borderline Personality Disorder occurred during the 12 months prior to the interview.

There are two time frames in which to code the presence of Borderline features: column I refers to the past (or enduring since early adulthood); column II refers to the last 12 months. Certain criteria must be present since early adulthood; but, unlike Antisocial Personality Disorder which can be diagnosed as early as adolescence, Borderline Personality Disorder cannot be diagnosed until early adulthood.

For a diagnosis to be considered current and past, onset occurred in the past, the subject must meet criteria prior to the last 12 months, and one or more symptoms are present within the last 12 months.

Criteria

A diagnosis of Borderline Personality Disorder requires the endorsement of at least five of nine symptoms enduring since early adulthood.
Some symptoms are broken down into several probes. The subject need not endorse every probe within an item in order to code “3.” For example, in Q1, if the subject reports “lots of highs and lows” in his close relationships, he can be coded “3” for this symptom even if he denies becoming “attached to people very quickly.”

**Middle Column**

As in early sections of the PRISM, the middle column of each question contains coding guidelines specific to the corresponding criterion. For example, the middle columns of questions 1-7, and 9 instruct you to exclude behaviors that occur only during discrete episodes of Major Depression, Mania, or psychotic disorders.

**Special Attention**

Q9a – If the subject denies impulsive behaviors code “1” in the appropriate column, and leave the adjacent boxes blank.

If the subject endorses any behavior, code “3” in the appropriate time frame and check all small boxes that apply.
Purpose

In PRISM Section 20, the interviewer’s observations of a subject’s behavior during the interview are coded. This section is completed immediately after the interview. In this section, important data that assists in diagnosis and analysis of data is coded. For example, if the subject appeared to be under the influence of drugs and/or alcohol, this would be noted in questions 1-7 (PRISM, p. 236). Another common observation made in this section is whether the subject minimized any of his/her experiences with alcohol, drugs, or depression. This is important data in understanding the subject’s responses, and in determining the reliability of the interview.

Narrative

Some of the observations made in Section 20 are elaborated in a narrative written by the interviewer (e.g., subject appeared uncomfortable answering alcohol and drug questions and may have minimized drug/alcohol use). The narrative is a brief synopsis of information gleaned during the interview and should reflect the interviewer’s thinking about the subject and the diagnosis. It can be a useful tool for the diagnostic supervisor to assess the accuracy of the diagnosis as well as a way of validating diagnoses during the data analysis phase. It is typically one to two pages in length, and it includes a paragraph of identifying and background information on the subject. Only information that helps to illustrate the subjects current or past mental health status should be included here. This might include psychiatric hospitalizations or levels of education which are indicative of higher levels of functioning. A brief summary of substance use should follow.

The narrative should continue with a brief summary of disorders (i.e., substance screening, substance use disorders, depression, psychosis, anxiety, personality disorders). The narrative should describe clearly the temporal relationship of substance use and all psychiatric disorders diagnosed. If the subject is subthreshold for a diagnosis, the interviewer should note this in the narrative.
GUIDELINES
AND GLOSSARY
Provide a brief explanation of the purpose of the interview before beginning, as determined by overall policy for the study. In research studies, this is a part of obtaining informed consent.

Stick to the questions as they are written, except for necessary minor modifications to take into account what the subject has already said, or to request elaboration or clarification.

Don’t apologize for using a structured interview.

Because of the structured nature of the PRISM, there is a tendency for the subject to notice that a “Yes” response to the initial probe in a section results in follow up questions; whereas, a “No” response results in a skip to the next section. This leads some subjects to give “No” responses as a way of speeding the interview along. If this is happening, stop the interview and ask the subject to answer the questions as honestly as possible.

Politely, but firmly, confront inconsistencies in the subject’s responses to questions as they arise. You can always explain that you are trying to make sure you understand what they are telling you so that you don’t put them on the spot and make them feel defensive.

Periodically check to make sure you and the subject are focusing on the same time period.

Proceed sequentially through the PRISM 6.0 sections unless an instruction tells you to skip to another section.

When a subject responds, “I don’t know,” or “I don’t remember,” always ask the subject to give their best estimate.

Always code in whole numbers. For example, when a subject reports their depression occurred a month and a half ago, clarify this as being approximately 6 weeks ago. Then, code “6 weeks ago” in the space provided. If a subject cannot say if their depression occurred 6 or 7 weeks ago, ask the subject for their best guess.

Communicate a non-judgmental and accepting attitude toward the subject at all times. For example, never label behaviors and experiences as problems unless the subject describes them as such.

Maintain a professional, pleasant demeanor toward the subject. This will help to put the subject at ease and create a pleasant and productive atmosphere. Your reaction to their responses should be benign whenever possible. A neutral reaction is very important to avoid encouraging some types of responses over others.
active phase of schizophrenia – “presence of two or more of the following: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, negative symptoms, for at least one month (or less than one month if symptoms are successfully treated or bizarre delusions/pathognomonic hallucinations (DSM-IV, p. 273).”

affective flattening – “restriction in the range and intensity of emotional expression (DSM-IV, p. 275).” Commonly found in the schizophrenia-spectrum disorders.

allogia – a symptom in schizophrenia characterized by an impoverishment in the range and intensity of fluency and productivity of speech.

avolition – a symptom in schizophrenia characterized by a restriction in motivation to begin, participate in, or complete goal-directed behavior.

baseline – an established point from which to measure the onset or exacerbation of a symptom.

binge – 3 or more days of continuous substance use.

bizarre delusions – strongly held beliefs that “are clearly implausible and not understandable and do not derive from ordinary life experiences (DSM-IV, p. 275).”

catatonic behavior – behavior that “includes a marked decrease in reactivity to the environment, maintaining a rigid posture and resisting efforts to be moved, active resistance to instructions or attempts to be moved, the assumption of inappropriate or bizarre postures, or purposeless and unstimulated excessive motor activity (DSM-IV, p. 276).”

chronic intoxication – intoxication four or more days a week for three or more weeks (i.e., more than half the days for a month or longer); for alcohol, must be four or more drinks per day.

co-morbidity – the co-occurrence of two or more pathological states.

disorganized behavior/speech – socially-inappropriate, peculiar, or meaningless activity or speech.

duration – the length of time that a mental disturbance or the symptoms of a mental disturbance were experienced.

expected effects of intoxication and withdrawal – experiences that would be expected from the substance ingested or the abrupt cessation of use.

heavy and prolonged use – use of a substance for more than half the days for a month or longer (i.e. four or more days a week for three or more weeks) for alcohol, must be four or more drinks per day.

intoxication – abnormal behavioral, psychological, physiological, and cognitive effects “due to the recent ingestion of (or exposure to) a substance (DSM-IV, p. 183).”
**minimal use** – use of a substance less than four days a week unless substance was used in a binge pattern.

**negative psychotic symptoms** – “symptoms which reflect a diminution or loss of normal functions (p. 275)” (i.e. affective flattening, alogia, avolition, anhedonia).

**occasional use** – substance use less than 4 days a week unless substance was used in a binge pattern.

**offset** – the most recent time when full criteria for a disorder were met; or the time any symptom for a disorder occurred.

**onset** – the time when full criteria for a disorder was first met; or the time a period of mental disturbance began or the time a symptom began.

**pathognomonic hallucinations** – complex auditory hallucinations that involve hearing two or more voices conversing with each other or one voice keeping up a running commentary on the individual’s behavior or thoughts.

**positive psychotic symptoms** – “symptoms which reflect an excess or distortion of normal functions, (DSM-IV, p. 274)” i.e. delusions, hallucinations, disorganized speech, disorganized or catatonic behavior.

**primary mental disorder** - begins prior to heavy substance abuse, or begins during heavy substance use and continues for four or more weeks after cessation of use, or occurs during a period of abstinence or occasional use and is not due to a general medical condition or exposure to a toxin.

**prodromal phase** – period just prior to active phase of schizophrenia during which changes in behavior (i.e. eccentric behavior, emotional outbursts) or functioning (i.e. social isolation, poor hygiene) occur.

**recurrence** – full criteria for disorder recur.

**relevant medical condition** – physical illness that causes symptoms mimicking psychiatric illness or symptoms (e.g., Cushing’s Disease, Multiple Sclerosis).

**relevant substance** – a substance is considered relevant to a specific mental disorder when intoxication or withdrawal from that substance mimic the symptoms of the mental disorder.

**remission (full)** – the absence of all symptoms of a diagnosed disorder; for most mental disorders, full remission is a symptom-free two month period; for alcohol and drug disorders, remission is 12 symptom-free months.

**remission (partial)** – full criteria for a diagnosed disorder are no longer met, but the subject is not in full remission (e.g., improvement in an episode of Major Depression such that 5(+) symptoms are no longer present, but the subject is not yet symptom-free).

**residual phase** – period just after the active phase of schizophrenia characterized by the persistence of changes in behavior such as eccentric behavior, emotional outbursts, or in functioning (i.e. social isolation, poor hygiene).

**subject’s own equivalent** – “SOE”- subject’s own words or expression.
substance abuse – a maladaptive pattern of recurrent substance use leading to clinically significant impairment or distress in one or more specified areas of functioning. The subject must endorse at least one out of four abuse symptoms.

substance dependence – a pattern of substance use which leads to clinically significant impairment or distress in an individual’s functioning. The subject must have three or more dependence symptoms co-occurring within a 12 month period.

substance-induced disorder – all symptom criteria for the disorder are met; the episode occurs entirely during a period of chronic intoxication or binge use OR within the first four weeks after cessation of use; substance is “relevant” to the disorder (i.e., its effects can cause symptoms mimicking the disorder being assessed); symptoms are greater than the expected effects of intoxication and/or withdrawal.

threshold – the point at which symptom severity, frequency, or duration meet diagnostic criteria.

withdrawal – the four week period following cessation of chronic intoxication or binge use.

Reference