USER’S MANUAL FOR THE
STRUCTURED CLINICAL INTERVIEW FOR DSM-5 SLEEP DISORDERS – REVISED
(SCISD-R)

Suggested Citation:

Note:
Before using the SCISD-R, please check back on the website listed in the citation for any updates to the manual or the instrument (denoted by date listed in the header of the manual and footer of the SCISD-R instrument).
TABLE OF CONTENTS

1. INTRODUCTION
2. HISTORY OF THE SCISD-R
3. DIAGNOSTIC AND SCREENING COVERAGE
4. BASIC FEATURES OF THE SCISD-R
5. ADMINISTRATION OF EACH SECTION
6. DO’S AND DON’TS
7. RESOURCES FOR ADDITIONAL TRAINING IN SLEEP MEDICINE
8. REFERENCES
1 INTRODUCTION

The Structured Clinical Interview for Sleep Disorders-Revised (SCISD-R) is a semi-structured interview for diagnosing sleep disorders according to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5; American Psychiatric Association, 2013). The SCISD-R was developed to allow clinicians to systematically obtain a sleep history, diagnose certain sleep disorders, screen for sleep disorders that require additional objective assessment for a diagnosis (see Section 3 below), and gauge the relative contribution of psychological, behavioral, environmental, and medical factors to sleep disorders when relevant. It is designed to be administered by a clinician or trained health professional who is familiar with DSM-5 sleep disorder classifications and diagnostic criteria. In addition, the interviewer should have basic knowledge regarding psychological and biological mechanisms of sleep and wakefulness as well as familiarity with conducting structured interviews. Those interested in advanced online training in the above areas can visit CBTiweb.org. The language and diagnostic coverage of the SCISD-R makes it appropriate for the assessment of adults (i.e., individuals >18).

2 HISTORY OF THE SCISD-R

Development of the SCISD-R began in 2011 when the DSM-5 was still in development. The original SCISD was designed to be consistent with the basic formatting and structure of the Structured Clinical Interview for DSM-IV Axis I Disorders available at the time (SCID-I; First, Spitzer, Gibbon, & Williams, 2002), and items corresponded to the diagnostic criteria recommended by the DSM-5 Sleep-Wake Disorders Workgroup that was available at the time. The resulting SCISD was then included in a research project and underwent psychometric evaluation (Taylor et al., 2018). Overall, there was excellent interrater reliability for insomnia ($r=1.0$) and restless legs syndrome ($r=0.83$); very good reliability for nightmare disorder (0.78) and obstructive sleep apnea hypopnea ($r=0.73$); and good reliability for hypersomnolence ($r=0.50$) and circadian rhythm sleep-wake disorders ($r=0.50$). The current version of the measure (SCISD-R) was revised to be consistent with the DSM-5.

3 DIAGNOSTIC AND SCREENING COVERAGE

3.1 Diagnostic and Screening Coverage of SCISD-R Sections

Table 1 below denotes which sections of the SCISD-R evaluate each sleep disorder. The SCISD-R can be used to diagnose certain sleep disorders and to screen for other sleep disorders that require additional objective and/or medical assessments (such as overnight polysomnography) as indicated in the “SCISD-R Usage” column.

<table>
<thead>
<tr>
<th>Disorders</th>
<th>Types</th>
<th>SCISD-R Usage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insomnia Disorder</td>
<td></td>
<td>Diagnosis</td>
</tr>
<tr>
<td>Hypersomnolence Disorder</td>
<td></td>
<td>Diagnosis</td>
</tr>
<tr>
<td>Circadian Rhythm Sleep-Wake Disorders</td>
<td>Delayed Sleep Phase Type</td>
<td>Diagnosis</td>
</tr>
<tr>
<td></td>
<td>Advanced Sleep Phase Type</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Shift Work Type</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Irregular Sleep-Wake Type</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-24-Hour Sleep-Wake Type</td>
<td></td>
</tr>
<tr>
<td>Obstructive Sleep Apnea (OSA) Hypopnea Syndrome</td>
<td>Screen: Polysomnography Required</td>
<td></td>
</tr>
<tr>
<td>Restless Legs Syndrome</td>
<td></td>
<td>Diagnosis</td>
</tr>
</tbody>
</table>
Nightmare Disorder  |  Diagnosis  
---|---
Non-Rapid Eye Movement (REM) Sleep Arousal Disorders  |  Sleepwalking  
|  Sleep Terrors  
REM Sleep Behavior Disorder  |  Screen: Polysomnography Required  
Narcolepsy  |  Screen: Medical Assessment and Polysomnography Required

The order of the interview does not follow the order that the disorders are described in the DSM-5. Instead the interview was designed to facilitate efficient differential diagnosis, beginning with the disorders of insomnia and hypersomnolence and then progressing to those diagnosable with interview and those which require advanced medical assessments.

### 3.2 Other Sleep Disturbances NOT included in the SCISD-R

Several sleep disturbances are not included in the SCISD-R for various reasons noted below. However, they are briefly described here so that interviewer has awareness of these conditions if they are reported during the course of the interview.

**3.2.1 Insufficient Sleep**

Insufficient Sleep, also referred to as “Behaviorally Induced Insufficient Sleep Syndrome” in the International Classification of Sleep Disorders (ICSD-3), is not included as a diagnosis in the DSM-5 but is important to consider as part of a differential diagnosis. Insufficient sleep occurs when an individual regularly fails to get enough sleep to maintain adequate alertness during waking hours. In other words, a person restricts their own opportunity for sleep (e.g., due to work or social obligations) to the point that it impacts their functioning. Insufficient sleep can be characterized by extreme discrepancies in sleep duration (e.g. short on workdays and long on weekends) and can result in excessive daytime sleepiness, unintentional napping, accidents, and cognitive impairments. If a patient presents with these complaints, ensure that they are not voluntarily restricting their own sleep opportunity before offering an alternative diagnosis (e.g., insomnia, hypersomnolence).

**3.2.2 Hypnopompic and Hypnogogic Hallucinations**

Hypnopompic and Hypnogogic Hallucinations occur during the transition between wakefulness and sleep. Patients report seeing things that are not there (e.g., figures in the room). Hypnagogic hallucinations occur at sleep onset, and hypnopompic hallucinations occur at sleep offset. These experiences can be confusing or distressing to patients but are unlikely to indicate a significant problem. The likelihood of these hallucinations increases in the context of sleep deprivation due to intentional restriction of sleep or an underlying sleep disorder. In rare cases, these hallucinations can be a symptom of narcolepsy but other symptoms should be confirmed before presuming hypnagogic and hypnopompic hallucinations indicate underlying sleep pathology.

**3.2.3 Sleep Paralysis**

Sleep Paralysis is not included in the SCISD-R because it is not a diagnosis in DSM-5. During sleep paralysis, the patient experiences a feeling of being conscious but an inability to move or speak for a few seconds up to a few minutes. Some patients may also feel pressure or a sense of choking. Sleep paralysis occurs when a patient passes between stages of wakefulness and sleep and tends to occur during periods of stress or sleeping in a different environment.

**3.2.4 Periodic Limb Movement Disorder (PLMD)**

Periodic Limb Movement Disorder (PLMD) was not included in the SCISD-R because it is not included in DSM-5. In PLMD, patients experience repetitive movements during sleep, most typically in the lower limbs, that occur about every 20-40 seconds. These movements are brief muscle twitches, jerking movements, or an upward flexing of the feet. They cluster into episodes...
lasting anywhere from a few minutes to several hours. These symptoms are often reported by a bed partner because they occur while the patient is asleep. PLMD can decrease sleep quality and cause excessive daytime sleepiness or fatigue. Diagnostic polysomnography (PSG) is required to diagnose PLMD.

3.2.5 Central Sleep Apnea and Sleep-Related Hypoventilation were not included because a) they are almost impossible to screen for using an interview, and b) PSG is required to differentiate these from obstructive sleep apnea.

3.2.6 Substance/Medication-Induced Sleep Disorder is also not specifically included but assessment of substance and medication use is included in the interview.

4 BASIC FEATURES OF THE SCISD-R

4.1 Sleep Patterns and Comorbid Mental and Medical Health History
The SCISD-R begins with sections to assist in the documentation of comorbid medical and mental health problems, medication and substance use, and typical sleep patterns. The Sleep Patterns section is consistent the Self-Assessment of Sleep Survey-Split (SASS-Y) which assesses weekday/weekend sleep separately (Dietch, Sethi, Slavish, & Taylor, 2019). This measure has been found to have good psychometric properties compared with the Consensus Sleep Diary that was developed by insomnia experts to provide a standardized diary for clinical and research work (Carney, et al., 2012). This section of the SCISD-R was designed so that it could be administered either via interview or self-report format. The information gathered in this section will help guide the rest of the interview.

4.2 Three-Column Format
A three-column format is used for all additional sections of the SCISD-R. From left to right, the columns include “Questions,” “Criteria,” and “Present.” The left-most “Questions” column contains structured questions and optional follow-up questions, where applicable, that the interviewer uses to obtain the necessary information from the patient. The middle column lists the DSM-5 diagnostic criteria that is being considered with each question. The right-most “Present” column lists the scoring options where the interviewer makes a determination regarding each “Criteria” and each sleep disorder. See example below:

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>CRITERIA</th>
<th>PRESENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. [If not known] Do you ever have difficulty falling asleep, staying asleep, or waking up too early in the morning? [Note. “Difficulty” is typically defined as &gt; 30.</td>
<td>1. A predominant complaint of dissatisfaction with sleep quantity or quality, associated with one (or more) of the following symptoms:</td>
<td>? 1 2 3</td>
</tr>
<tr>
<td>1. Difficulty initiating sleep</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4.3 Section Format
Each section first lists the numbered criteria that are each individually rated, followed by the sleep disorder in bold that is given a preliminary rating at the end of each section. Some sections then include prompts to obtain information needed for DSM-5 specifiers (e.g., mild, moderate, or severe; acute, subacute or chronic).
4.4 Scoring Criteria

Ratings in the SCISD-R reflect the evaluation of the specific DSM-5 diagnostic criteria of a given sleep disorder. During administration, criteria are rated by circling the ?, 1, 2, or 3 in the “Present” column where ? = Insufficient information, 1 = Absent (no), 2 = Subthreshold, and 3 = Threshold (yes; see Table 2).

<table>
<thead>
<tr>
<th>Table 2. Descriptive Classification of SCISD-R Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Score</td>
</tr>
<tr>
<td>?</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
</tbody>
</table>

These scoring classifications are also listed in the header of each page for the interviewer’s convenience.

Preliminary diagnosis decisions are indicated by circling the ?, 1, 2, or 3 in bold at the bottom of each section. For example, in the Insomnia Disorder section (on page 4 of the SCISD-R), the final line of text in bold (before the note section) is where a preliminary diagnosis decision would be indicated for this disorder. Remember to ensure that all bolded rows of text are completed (i.e., scored) before progressing to the next section.

4.5 Summary Page

The Summary Page at the end of the SCISD-R is where final differential diagnosis and screening decisions are made along with specifiers for any disorders that are determined to be present.

4.6 Labels & Instructions for Interviewers

4.6.1 [If not known]

It is common for the SCISD-R to be included as a part of a larger assessment and questions within different sections of the SCISD-R may cross-reference each other. It is possible that questions can become repetitive and the interviewer is encouraged to use their clinical judgment to reduce burden on the patient if information is already known. Therefore, the SCISD-R includes “[If not known]” prior to questions that are the most likely to be redundant. For these questions, if the information is already known to the interviewer, the interviewer may skip the question and score the associated criteria using information obtained previously.

4.6.2 ALL CAPITAL LETTERS, BOLD, ITALIC, AND UNDERLINED

Special instructions for the interviewer are listed at the top of certain sections in the following format: **CAPS, BOLD, ITALIC, AND UNDERLINED.** These are important notes for the interviewer that should be read and considered prior to administering the section. The following sections include special instructions: Hypersomnolence Disorder, Circadian Rhythm Sleep-Wake Disorders, Non-REM Sleep Arousal Disorders (Sleepwalking and Sleep Terrors), and Narcolepsy.

4.6.3 BOLD, ALL CAPITAL LETTERS

Skip logic is included at the bottom of sections in **BOLD, CAPITAL LETTERS.** For example, at the bottom of the Insomnia Disorder section, the skip logic states, “**IF 1 TO ANY ITEM, GO TO NEXT SECTION.**” In other words, if the score for any insomnia disorder criteria (1-6) is “1”, the interviewer should score the preliminary diagnosis for insomnia disorder as “1” and then proceed to the next section of the SCISD-R.
5 ADMINISTRATION OF EACH SECTION

5.1 Medical History, Mental Health History, Medications, and Substances
- Pages 1-3 assessing medical and mental health history and sleep patterns are designed to be administered either via interview of via self-report, the latter of which may reduce the time required for the interview.
- Page 1 of the SCISD-R begins assessment of medical and mental health problems, which will be referenced during the rest of the SCISD-R.
- Page 1 also assesses medications and substances that can impact sleep including the indication of the substance, how often it is taken or used, the dose, and duration of use. The indication of use can be helpful in assessing sleep disorders. For example, the purpose of the patient’s alcohol use may be to help him/her fall asleep and/or as a social activity.

5.2 Sleep Patterns
- Page 2 begins with a general question regarding the patient’s sleep, “Currently, what are your main concerns about your sleep?” This question functions to obtain a “chief complaint” from the patient and identify what is bothering them the most about their sleep. Once this information is gathered, the interviewer will move on to the table which includes more detailed questions about the patient’s sleep. Next, questions assess sleep patterns for a typical work night (e.g., week night). These questions are based on the Self-Assessment of Sleep Survey-Split (SASS-Y; Dietch, Sethi, Slavish, & Taylor, 2019).
- The bottom of page 2 includes a section for the estimated time in bed and the estimated total sleep time can be entered. This will help guide other sections of the interview. (For example, Insomnia Disorder section item 5a assesses the DSM-5 criteria that states “The sleep difficulty occurs despite adequate opportunity [e.g., lasting at least 7 hours] for sleep” and the Hypersomnolence Module is only assessed if the patient reports sleeping at least 7 hours per night.)
- Page 3 begins with the question “Is your sleep the same on days when you work (e.g., work week) as days when you are off of work (e.g., weekends)?” If yes, all of the sleep pattern questions are repeated for off work nights (e.g., weekend nights). The language “work nights” and “off work” is used as this terminology is applicable to patients who may not adhere to a conventional Monday to Friday work week.
- The bottom half of page 3 functions to gather additional information about the patient’s sleep wake cycles which will guide the rest of the interview. The question asking “If you had no responsibilities, what time would your body tell you to go to sleep and wake up?” helps the interviewer to determine if a Circadian Rhythm Sleep-Wake Disorder is likely present (e.g., delayed sleep phase type) and guide the questions for the Circadian Rhythm Sleep-Wake Disorders section of the interview.
- Again, the bottom of page 3 includes a section for the estimated time in bed and the estimated total sleep time can be entered for off work nights/weekends. Calculate these values based on the information provided in questions 1-7 (week nights) and 11-17 (week days). First, calculate Time in Bed by calculating the amount of time between “What time do you try to go to sleep, on average (questions 2, 12) and “What time do you usually get out of bed for the day, on average?” (questions 7, 17). Then, to calculate Total Sleep Time, subtract Sleep Onset Latency (“…how long does it take you to fall asleep, on average” [questions 3, 13]), Wake After Sleep Onset (“How long do these awakenings last…?” [questions 5, 15]), and Terminal Wakefulness (time between questions 6-7/16-17). If the individual has significant nap duration (questions 8, 18), you may also want to calculate a separate “24 hour Total Sleep Time” by adding nap time to the Total Sleep Time described above. This will help guide other sections of the interview. (For example, Insomnia Disorder section item 5a assesses the DSM-5 criteria that states “The sleep difficulty occurs despite adequate opportunity [e.g., lasting at least 7 hours] for sleep” and the Hypersomnolence Module is only assessed if the patient reports sleeping at least 7 hours per night.)
5.3 Insomnia Disorder

- For insomnia disorder, 7 diagnostic criteria are necessary. Skip logic for this section states that, once any criteria is scored “1” (absent), the interviewer should rate the preliminary diagnosis for insomnia disorder as “1” and go to the next section.
- Please note that the DSM-5 has additional specifiers for Insomnia Disorder based on duration of symptoms which are excluded from this interview (p. 363) for reasons noted below. The specifiers are as follows:
  - Episodic: Symptoms last at least 1 month but less than 3 months. Note: Episodic insomnia is not diagnosed as “Insomnia Disorder.” If an individual meets all criteria for Insomnia Disorder except for duration criteria (i.e., insomnia lasting less than 3 months), this should be coded as “Other Specified Insomnia Disorder.”
  - Persistent: Symptoms last 3 months or longer. This is consistent with the other criteria for Insomnia Disorder so, by definition, if someone meets criteria for Insomnia Disorder, they meet criteria for the “Persistent” specifier.
  - Recurrent: Two (or more) episodes within the space of 1 year. This specifier is outside the scope of the interview.
- The bottom of the Insomnia Disorder section includes an important note relating to Items 1, 5, and 7.
  - The criteria for Item 1 is: “A predominant complaint of dissatisfaction with sleep quantity or quality, associated with one (or more) of the following symptoms: Difficulty initiating sleep, maintaining sleep, (i.e. frequent awakenings or problems returning to sleep after awakenings), and early-morning awakenings with inability to return to sleep.”
    - The note clarifies that, according to DSM-5, “When a complaint of nonrestorative sleep occurs in isolation (i.e., in the absence of difficulty initiating and/or maintaining sleep) but all diagnostic criteria with regard to frequency, duration, and daytime distress and impairments are otherwise met, a diagnosis of other specified insomnia disorder or unspecified insomnia disorder is made” (p. 363). It is important for the interviewer to note that, for this type of diagnosis, the insomnia is present without difficulty initiating and/or maintaining sleep because this will have different treatment implications (e.g., sleep restriction may not be effective).
  - The criterion for Item 5 is: “The sleep difficulty occurs despite adequate opportunity [e.g., lasting at least 7 hours] for sleep.” The DSM-5 does not define “adequate opportunity for sleep” in the insomnia disorder diagnostic criteria, but does indicate “despite a main sleep period lasting at least 7 hours” in the hypersomnolence disorder diagnostic criteria, so this example was used in the insomnia definition” in brackets (“e.g., lasting at least 7 hours”).
  - The criterion for Item 7 is: “Coexisting mental disorders and medical conditions do not adequately explain the predominant complaint of insomnia.” The note states that DSM-5 specifies that insomnia “may occur during the course of another mental disorder or medical condition, or it may occur independently” (p. 363).

5.4 Hypersomnolence Disorder
For hypersomnolence disorder, 6 criteria are necessary. Skip logic for this section states that, once any criterion is scored “1” (absent), the interviewer should rate the preliminary diagnosis for hypersomnolence disorder as “1” and go to the next section.

It is important to attend to the instruction for interviewers at the top of the section: **“ASK ONLY IF PATIENT REPORTS SLEEPING AT LEAST 7 HOURS PER NIGHT ON AVERAGE.”** If the patient reported sleeping less than 7 hours per night on average when describing their sleep functioning on the first page of the SCISD-R, the interviewer is instructed to score hypersomnolence disorder as “1” (absent) and go to the next section.

### 5.5 Circadian Rhythm Sleep-Wake Disorders

- This section is largely guided by information gathered from pages 2-3 of the SCISD-R.
- It is important to attend to the instruction for interviewers at the top of the section: **“ASK ONLY IF PATIENT REPORTS INSOMNIA SYMPTOMS OR HYPERSONMNOLENCE SYMPTOMS.”** The interviewer should only ask these questions if the patient endorsed insomnia symptoms or hypersomnolence symptoms (e.g., excessive daytime sleepiness, excessive napping, unintentional dozing).
- If the patient does not endorse any criteria 1-5, the interviewer should score the preliminary diagnosis for circadian rhythm sleep-wake disorder as “1” and go to the next section (Obstructive Sleep Apnea Hypopnea Syndrome section). However, if the patient endorses any of the criteria for 1-5, the interviewer is instructed to ask questions 6 and 7 in regard to the type of sleep-wake disturbance endorsed; this allows the interviewer to determine if a diagnosis of circadian rhythm sleep-wake disorder is warranted.
- The interviewer should ALWAYS query Shift Work Type; it is important to clarify if the patient engages in shift work by asking: “*Does your shift ever start before 6 a.m. or end after 9 p.m.?*” Patients may not always consider this to be shift work.
- Questions 8 and 9 for this section are not required for a diagnosis of circadian rhythm sleep-wake disorder. These questions are used to inform diagnostic specifiers on the Summary Page at the end of the interview.

### 5.6 Obstructive Sleep Apnea Hypopnea Syndrome

- For this section, it is important to note there is no skip logic. Therefore, the interviewer is instructed to ask all questions in order to score all 4 criteria.
- This section is different from the previous sections in that not all criteria are necessary for a preliminary diagnosis. Specifically, a rating of 3 on ≥ 2 criteria will result in an overall rating of 3.
- Furthermore, it is important for the interviewer to understand that obstructive sleep apnea (OSA) must be confirmed by diagnostic PSG. Therefore, this section serves as a screen for possible OSA unless the patient has previously undergone a PSG and has received a diagnosis.
- It is very important to ask the patient if they have received a PSG prior to the interview and record their answer at the bottom of the section in the designated area allotted. If the patient has been diagnosed with OSA per PSG, score the rating in the “Present” column as “3” regardless of scores for criteria 1-4. If the patient has been diagnosed with OSA, it is possible that their OSA diagnosis is being treated and thus their symptoms have improved. However, the condition is still present and so a rating of “3” is appropriate.
- If a patient has been diagnosed with OSA, it will be helpful to ask if the patient is being treated for OSA, typically using Continuous Positive Airway Pressure (CPAP). This will inform the assessment and treatment and this information will be noted on the Summary Page at the end of the interview.
5.7 Restless Legs Syndrome

- For restless legs syndrome, 10 criteria are necessary. Skip logic for this section states that, once any criteria is scored “1” (absent), the interviewer should score the preliminary diagnosis for restless legs syndrome as “1” and go to the next section (Nightmare Disorder section).
- It is often difficult for patients to describe the unpleasant sensations accompanying restless legs syndrome. Because of this, it is important for the interviewer to ask open ended questions when gathering information about a patient’s urge to move their legs. If the patient is having difficulty describing the sensation, the interviewer is encouraged to ask follow-up queries that may be helpful to the patient. Some example sensation descriptions are provided in question 1b.

5.8 Nightmare Disorder

- For nightmare disorder, 5 criteria are necessary. Skip logic for this section states that, once any criteria is scored “1” (absent), the interviewer should score the preliminary diagnosis for nightmare disorder as “1” and go to the next section (Non-REM Sleep Arousal Disorders section).
- It is important to note that, although criterion 1 describes “repeated occurrences” of dreams, the dreams do not have to be the exact same every time to constitute a diagnosis of nightmare disorder. Rather, the extended, dysphoric, well-remembered dream should occur more than once.
- Criteria 1c-1e are not necessary for a score of “3” for criterion 1 but are included in the assessment to facilitate full assessment of the DSM-5 criteria.
  - Item 1d indicates that the dreams, “generally occur during the second half of the major sleep episode.” It is important to note that interviewees often have difficulty recalling the timing of nightmares and are unable to answer and this alone does not preclude a diagnosis.
  - For item 1e, the verbiage “that usually terminate with awakening and rapid return of full alertness,” is not included in the DSM-5 criteria but is included in the “Diagnostic Features.” This is further delineated in the note at the bottom of the Nightmare Disorder section which states, “According to DSM-5, nightmares usually terminate with awakening and rapid return of full alertness. However, the dysphoric emotions may persist into wakefulness and contribute to difficulty returning to sleep and lasting daytime distress. Some nightmares, known as ‘bad dreams,’ may not induce awakening and are recalled only later” (p. 405). Item 1e was included in the assessment because some clinicians and researchers may be interested in distinguishing between “bad dreams” that “may not induce awakening” from nightmares that “usually terminate with awakening.”
- Questions 6 and 7 for this section are not required for a diagnosis of nightmare disorder. DSM-5 does not include a criterion evaluating the frequency or duration of distressing dreams for nightmare disorder. These questions are used to inform diagnostic specifiers on the Summary Page at the end of the interview.

5.9 Non-REM Sleep Arousal Disorders

- There are two sections for Non-REM Sleep Arousal Disorders: Sleepwalking Type (page 10) and Sleep Terror Type (page 11). Both sections require all 7 criteria to be met for a diagnosis and contain skip logic.
  - Skip logic for the Non-REM Sleep Arousal Disorders: Sleepwalking Type section states that, once any criteria is scored “1” (absent), the interviewer should score the preliminary diagnosis for non-
REM sleep arousal disorders: sleepwalking as “1” and go to the next section (non-REM sleep arousal disorders: sleep terrors).

- Skip logic for the Non-REM Sleep Arousal Disorders: Sleep Terrors Type section states that, once any criteria is scored “1” (absent), the interviewer should score the preliminary diagnosis for non-REM sleep arousal disorders: sleep terrors as “1” and go to the next section (REM sleep behavior disorder).

- It is important to attend to the instruction for interviewers listed at the top of both sections: **RECURRENT EPISODES OF INCOMPLETE AWAKENING FROM SLEEP, USUALLY OCCURRING DURING THE FIRST THIRD OF THE MAJOR SLEEP EPISODE, ACCOMPANIED BY THE FOLLOWING.**

- Questions 8 and 9 of the Sleepwalking Type section are not required for a DSM-5 diagnosis of a non-REM sleep arousal disorder but can be used to obtain information about important (but relatively rare) specifiers, “with sleep related eating” and “with sleep-related sexual behavior (sexsomnia.)” Since these behaviors occur during sleep, the individual may be unsure or have difficulty recalling whether this occurs. It may be helpful to additionally prompt them by asking whether others have told them this occurs, or whether they have found evidence of these behaviors when awake.

- Questions 10 and 11 of the Sleepwalking Type section and questions 8 and 9 of the Sleep Terror Type section are not required for a DSM-5 diagnosis of a non-REM sleep arousal disorder. These questions are instead used to inform diagnostic specifiers on the Summary Page at the end of the interview.

- For the sleep terrors type section, it is important to differentiate waking with intense fear/terror from nightmares. Clarifying questions are included for the interviewer (see questions 1a and 1b); interviewers are reminded to query about this important differentiation by the text that states ‘[If nightmares are endorsed clarify “aside from a nightmare”]’ at the end of Item 1.

### 5.10 REM Sleep Behavior Disorder

- REM sleep behavior disorder is similar to OSA in that it cannot be diagnosed by interview alone. A diagnosis of REM sleep behavior disorder also requires confirmation by PSG or all criteria in conjunction with a diagnosis of synucleinopathy (a neurodegenerative disease such as Parkinson’s disease, dementia with Lewy bodies, or multiple system atrophy). Because of this, it is important for the interviewer to ask all patients if they have undergone PSG or received a synucleinopathy diagnosis and record their answer in the designated area provided at the bottom of the section.

- For possible REM sleep behavior disorder, 6 criteria are necessary. Skip logic for this section states that, once any criteria is scored “1” (absent), the interviewer should score the preliminary diagnosis for REM sleep behavior disorder as “1” and go to the next section (Narcolepsy section).

- However, prior to moving on to the next section, the interviewer must ask the patient if he/she has received a diagnosis of REM sleep behavior disorder as confirmed by PSG or if they have an established synucleinopathy (neurodegenerative disease) diagnosis. If they have received a diagnosis per PSG score, definite diagnosis for REM sleep behavior disorder is scored as a “3” regardless of the ratings for criteria 1-6.

### 5.11 Narcolepsy

- It is important to attend to the instruction for interviewers listed at the top of this section: **ASK ONLY IF PATIENT MEETS CRITERIA FOR HYPERSOMNOLENCE DISORDER.** As designated by these instructions, questions in this section should only be asked if the patient meets DSM-5 criteria for hypersomnolence disorder.

- Narcolepsy is similar to OSA and REM sleep behavior disorder in that it cannot be diagnosed by interview alone. A diagnosis for narcolepsy requires confirmation by either PSG or a cerebrospinal fluid (CSF) tap.
Because of this, it is important for the interviewer to ask patients if they have undergone PSG or a CSF tap and record their answer in the designated area provided at the bottom of the section.

- For possible narcolepsy, 4 criteria are necessary. Skip logic for this section states that, once any criteria is scored “1” (absent), the interviewer should score the preliminary diagnosis for narcolepsy as “1” and go to the next section (Summary Page).
- However, prior to moving on to the next section, the interviewer must ensure they have asked the patient if they have ever received a diagnosis of narcolepsy as confirmed by either PSG or a CSF tap. If the patient has received a diagnosis of narcolepsy, the interviewer should score the preliminary diagnosis for narcolepsy as “3” regardless of the ratings for criteria 1-4.
- Questions 5 and 6 for this section are not required for a diagnosis of narcolepsy. These questions are instead used to inform diagnostic specifiers on the Summary Page at the end of the interview.

5.12 Summary Page

- The Summary Page at the end of the SCISD-R is where final differential diagnosis and screening decisions are made along with specifiers for any disorders that are determined to be present.
- As indicated on the Summary Page for insomnia disorder and hypersomnolence disorder, the interviewer should only rate a “3” if the disturbance is not better explained by and does not occur exclusively during the course of another sleep-wake disorder. This means that an interviewer may rate a “3” for insomnia disorder in the Insomnia Disorder section, but may list a “1” on the Summary Page if it is determined that the insomnia complaints are better explained by another disorder such as a circadian rhythm sleep-wake disorder.
- If a disorder is determined to be present, the Summary Page includes the DSM-5 Specifiers that should be completed using the information gathered during the interview.
- The Summary Page also has a location to indicate if certain conditions are already being treated with medications or Continuous Positive Airway Pressure (CPAP) therapy.

6 DO’S AND DON’TS

- DO develop rapport by using a conversational style and asking less structured follow-up questions.
- DO refer to previously gathered information (e.g., from pages 1-3, or prior modules) to save time and avoid asking redundant questions.
- DO review the entire SCISD-R and SCISD-R manual prior to conducting the interview with a patient. It is important for interviewers to familiarize themselves with the language and terminology used throughout the measure.
- DON’T stray unnecessarily or excessively from the content of the questions.
- DON’T provide the interview to the patient as a self-report measure (with the possible exception of pages the pre-interview, on pages 1-3). Clinical judgment of the trained interviewer is necessary to rate criteria based on patients’ responses.

7 RESOURCES FOR ADDITIONAL TRAINING IN BEHAVIORAL SLEEP MEDICINE

7.1 Books

7.2 Websites/Trainings

- Provider-focused, web-based learning course in cognitive behavioral therapy for insomnia: www.cbtiweb.org
- The Society of Behavioral Sleep Medicine Website: www.behavioralsleep.org
- The American Academy of Sleep Medicine Website: www.aasmnet.org
- The Center for Deployment Psychology Website: www.deploymentpsych.org
- Defense Centers of Excellence Wellness Resources for the Military Community: https://afterdeployment.dcoe.mil/topics-sleep
- University of Pennsylvania CBT-I Conference Website: http://www.med.upenn.edu/cbti/index.html
- University of Pennsylvania Case Review Webinar and telephone consultation: http://www.med.upenn.edu/bsm/cbt.html

8 REFERENCES


