August 17, 2007

To: Interested persons
Fr: Ron Kessler
Re: The CIDI-SF scales

As described by Kessler et al. (1998), the CIDI-SF scales were developed at the request of the U.S. National Center for Health Statistics (NCHS) for use in the Conditions Module of the redesigned U.S. National Health Interview Survey (NHIS). A pair of short screening scale of nonspecific psychological distress (K6/K10) was developed at the same time (Kessler et al., 2002). Some CIDI-SF scales and the K6/K10 are now in use in the NHIS as well as in the Substance Abuse and Mental Health Services Administration (SAMHSA) annual National Household Survey on Drug Abuse (NHSDA).

As detailed by Kessler et al. (1998), developmental work on the CIDI-SF was carried between 1993 and 1995 using the baseline NCS to generate a best short series of symptom questions among respondents who endorsed diagnostic stem questions. The OCD module was developed later by Gavin Andrews based on his National Survey of Mental Health and Well-Being in Australia using the same methods. We had hoped that either NIMH or SAMHSA would fund further methodological research, including a validation study. However, this never occurred. Since that time, Spitzer et al. (1995) developed the PRIME-MD and Sheehan et al. (1998) developed the MINI as alternative short diagnostic interviews, lessening the need for the CIDI-SF scales. Based on the availability of the PRIME-MD and MINI, we abandoned efforts to refine the CIDI-SF scales in the absence of funding from the NCHS.

We have informed the NCHS that calibration of the CIDI-SF scales included in the NHIS requires confirmatory clinical follow-up interviews and that a methodological study should be carried out to administer such interviews. In the absence of such data, the best calibrations available are those generated in the baseline NCS data. However, these should be considered only provisional in light of the fact that the fundamental survey conditions, order effects, and context effects of the NCS data collection are quite different from those for the CIDI-SF questions administered as stand-alone instruments.

Researchers who are interested in a short general-purpose screen for any disorder or for any serious mental disorder are referred to our work on the K6/K10 scales. Unlike the CIDI-SF, methodological research on the K6/K10 scales has been actively supported and calibration rules are available. For an overview of the K6/K10, see Kessler et al. (2002 and 2003). For information on comparative validity of the K6/K10, see Furukawa et al. (2003) Text and description of K6/K10 scoring can be found at http://www.hcp.med.harvard.edu/ncs/k6_scales.php

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Scoring the World Health Organization's Composite International Diagnostic Interview Short Form (CIDI-SF; v1.0 NOV98)

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As described elsewhere (Kessler et al., in press), the CIDI-Short Form (CIDI-SF) was developed to evaluate hierarchy-free diagnoses according to the definitions and criteria of the Diagnostic and Statistical Manual of Mental Disorders (APA 1994). The CIDI-SF evaluates six DSM-IV mental disorders and two DSM-IIIR substance disorders: major depression, generalized anxiety, specific phobia, social phobia, agoraphobia, panic attack, alcohol dependence and drug dependence. The CIDI-SF yields a probability-of-caseness ranging from 0.0 to 1.0 for each disorder. This score can be interpreted as the probability that a respondent with a particular response profile would meet full diagnostic criteria if given the complete CIDI interview. Because it may be desirable to have dichotomous outcomes defining whether the respondent is possibly a case (i.e. meets full non-hierarchical diagnostic criteria), guidelines for specifying these outcomes are also provided.

All items used in the CIDI-SF were selected from the larger pool of items that make-up the World Health Organization's (WHO) Composite International Diagnostic Interview (CIDI; WHO 1990) and were selected based on analyses of the US National Comorbidity Survey (NCS; Kessler et al., 1994). Although the empirical work to develop the CIDI-SF was based on lifetime diagnoses, the CIDI-SF is scripted in a 12-month prevalence format. Users who are interested in screening for lifetime prevalence can rescript the questions for this purpose.

The CIDI-SF uses a stem-branch logic in which a small number of initial diagnostic stem questions are used in each section to skip-out people who are least likely to be cases before they are asked further symptom questions. It is important to note that although no questions about organic exclusions are included in the CIDI-SF this exclusion was used in the empirical work to select the scale items and was taken into consideration in generating the probabilities of caseness. As a result, if you choose to ask additional questions about this exclusion and use them to exclude particular individuals, the probabilities of caseness reported here are no longer applicable. For more details on the development of the CIDI-SF, see Kessler et al. (in press).

Recognizing that the probabilities of caseness presented here may be limited in their generalizability to other populations and cultures, a major effort is currently being made to generate country-specific probabilities of caseness using data available through the International Consortium in Psychiatric Epidemiology (ICPE). The results of this work will be posted on the CIDI website (http://www.who.ch/msa/cidi/) when they become available. Until that time, we recommend using the current CIDI-SF probabilities of caseness. Alternatively, researchers could administer a complete CIDI section to those respondents screening positive to the CIDI-SF stem question for that section and generate their own probabilities of caseness. The former option makes sense if you believe that the results of the NCS are generalizable to your population, while the latter option is preferred if you are unwilling to make this assumption.

Scoring the CIDI-SF

A. Major depression (MD)

Section A of the CIDI-SF is designed to classify respondents according to the criteria of a DSM-IV major depressive episode. No distinction is made between respondents with major depressive disorder, major depressive episodes that occur as part of a bipolar disorder, or major depressive episodes that occur in the course of psychotic disorders.

There are two ways to meet the diagnostic stem requirement for MD: either to endorse all questions about having two weeks of dysphoric mood (A1-A1a-A1b) or to endorse all questions about having two weeks of anhedonia (A9-A9A-A9b). Note that each series requires the respondent to report two weeks of this symptom lasting at least most of the day, at least almost every day. Either denying the existence of the symptom or denying persistence leads to a skip-out and the respondent receives a probability of caseness equal to zero.

If the respondent endorses the A1-A1a-A1b stem series, an additional seven symptom questions are asked: losing interest (A1c=1), feeling tired (A1d=1), change in weight (A2b=1), trouble with sleep (A3a=1 or 2), trouble concentrating (A4=1), feeling down (A5=1), and thoughts about death (A6=1). The respondent's MD score (range 0-7) is then calculated as the sum of positive responses to each of these seven symptom questions.

Table 1 shows the cross-classification of MD short form scores with the probability of being a CIDI case. As explained earlier, this cross-classification reflects the probability that a respondent with a particular response profile will meet full diagnostic criteria when given the complete CIDI interview. As shown in the table, the probability of being a CIDI case is related to the MD score with the probability of being a case being greater than 0.5 among respondents who endorsed three or more of the seven symptoms.

Using the results in table 1, we propose two scoring alternatives for the CIDI-SF MD section. The first method is to classify respondents as either probable cases or probable non-cases based on whether or not they have a MD score of three or more. The second method is to assign respondents the probability of caseness that corresponds to their MD score. Note that respondents who denied the MD stem questions or otherwise skipped out of the section prior to assessing the seven symptoms in the MD score receive a probability of caseness equal to zero.

The A7 checkpoint is scripted so that the A8 series is administered to all respondents who endorse at least one symptom question. This branch is arbitrary because the A8 question series plays no part in generating predicted probabilities. Indeed, depending on the interests of the researcher the A8 series can be skipped entirely or administered only to respondents with a higher number of symptoms. The A8 series should be

asked if the researcher is interested in persistence (A8), recency (A8a), and impairments (A8b-A8e) associated with 12-month MD.

It is noteworthy that we did not use the A8b-A8e series to operationalize the DSM-IV requirement of distress or impairment. Our thinking here was similar to that of others who have criticized the DSM-IV for combining distress and impairment in a single criterion. This criterion can be met either by having 'clinically significant distress or impairment'. However, it is unclear how a person could have two weeks or more of dysphoria or anhedonia 'most of day nearly everyday' without being classified as having clinically significant distress. Our reading of this criterion, then, is that virtually anyone who qualifies for the assessment of MD by virtue of meeting the requirements of criterion A also qualifies for the distress-impairment criterion. For this reason, we have not required impairment in our recommended scoring of the CIDI-SF MD section or in any of the other CIDI-SF diagnosis sections.

The MD series ends after the A8 series for respondents who endorse the A1-A1a-A1b stem series. However, respondents who do not endorse this series are skipped to A9 from A1, A1a, or A1b (whichever is failed first). The A9-A9a-A9b series provides a second chance to meet the stem question requirement for a diagnosis of MD. Respondents who fail this series are skipped out of the section with a probability of caseness equal to zero. Those who pass through the series, though, are asked a series of six symptom questions (A9c-A14) identical to questions A1d-A6.

This second series has seven questions similar to the first series. The second stem question, A9, is equivalent to A1c. The seven questions refer to: losing interest ((A9a=1 or 2) and (A9b=1 or 2)), feeling tired (A9c=1), change in weight (A10b=1), trouble with sleep (A11a=1 or 2), trouble concentrating (A12=1), feeling down (A13=1), and thoughts about death (A14=1). The respondent's MD score (range 0-7) is then calculated as the sum of positive responses to the stem question and each of the six symptom questions.

As noted above, the results in table 1 can be used to classify respondents based on their MD score. The first method classifies respondents as either probable cases or probable non-cases based on whether or not they have a MD score of three or more. The second method assigns respondents the probability of caseness that corresponds to their MD score. Again, respondents who denied the MD stem questions or otherwise skipped out of the section prior to assessing the six symptoms in this MD score receive a predicted probability of zero.

Checkpoint A15 is equivalent to checkpoint A7. The considerations in deciding whether or not to administer the A16 series and, if so, to which respondents, are the same as those discussed above for the A8 series.

B. Generalized Anxiety Disorder (GAD)

Section B of the CIDI-SF is designed to classify respondents according to the criteria of DSM-IV generalized anxiety disorder. In contrast to

other CIDI-SF sections, this section allows for full diagnostic assessment. This means that if the diagnostic requirements are fulfilled the respondent receives a probability of caseness equal to one. Otherwise, the respondent receives a probability of caseness equal to zero. It is not possible to assign intermediate probabilities of caseness based on this assessment.

The diagnostic stem requirement for GAD is met when the respondent reports a period of feeling worried, tense, or anxious (B1 or B1a=1) that lasted at least 6 months (B2a or B2b>=6 months). Respondents who do not report an anxious period lasting at least 6 months are skipped out of the section and receive a probability of caseness equal to zero.

If an anxious period of sufficient duration is endorsed (B3=1), further qualifiers are asked to determine whether the period was excessive (B4=1), lasted more days than not (B5=1), and involved worrying about more than one thing (B6=2 or B8=1), all of which are necessary qualifiers for DSM-IV GAD criterion A. Lack of control over these worries (criterion B) is then assessed in a series of three questions (B7=1 or B9=1 or B10=1). Although these do not apply to the non-hierarchical GAD diagnosis, the types of worries are listed at the end of this question series (B11) so that exclusions as listed in DSM-IV criterion D could be evaluated (e.g. panic disorder, social phobia, obsessive-compulsive disorder and anorexia nervosa). The types of physiological symptoms that characterize the worried, tense, or anxious period (criterion c) are then assessed in questions B12a-g.

As outlined in table 2, given that respondents have endorsed an anxious period that lasted at least 6 months (B3=1), that the above mentioned qualifiers have been satisfied (B4=1 and B5=1 and either B6=2 or B8=1), that lack of control over this anxious period was endorsed (B7=1 or B9=1 or B10=1), and that at least 3 of the symptoms have been endorsed (B12a-g=1), a probability of caseness equal to one can be assigned. Otherwise, a probability of caseness equal to zero is assigned. As noted above, because this section is structured as a complete diagnostic assessment there are no intermediate probabilities.

Checkpoint B13 is similar to checkpoints A7 and A15 in the MD section and the considerations in deciding whether or not to administer this section are similar. These questions evaluate contact with a health care provider or other professional (B14-15), use of medication, drugs or alcohol (B16), and interference with daily functioning (B17).

C. Specific Phobia (SpP)

Section C of the CIDI-SF is designed to classify respondents according to the criteria of DSM-IV specific phobia with the exception that criterion G (exclusions for fears that are attributed to other mental disorders) is ignored.

The section begins by assessing types of unreasonably strong fears experienced by the respondent which are associated with ‘clearly discernable, circumscribed objects or situations’. Fears of this type are organized into four categories: natural environment (C1a),

situational (closed space; C1b), insect-animal (C1c) and blood-injection-injury (C1d). If no fears are endorsed (C2=2) the respondent is skipped out of the section and receives a probability of caseness equal to zero. Otherwise (C2=1), the question series goes on to evaluate the frequency of anxious response to the stimulus. If the respondent endorses a relatively infrequent response to the situation (C3=3 or 4 or 7) they are skipped out of the section and receive a probability of caseness equal to zero.

For those respondents who have endorsed an unusually strong fear (C2=1) with a sufficiently high frequency of response to the stimulus (C3=1 or 2), the subsequent questions evaluate for how long the fears have been experienced (C4=2 or 3, or C4a>=3 months), whether it interferes significantly with the R's life (C5=1), whether it causes distress (C6=1), and whether the fear is excessive or unreasonable (C7=1 or C8=1).

The specific phobia score (range 0-3) is calculated by summing the number of positive responses to questions C5, C6, C7/C8. However, because there is no skip-out for respondents who reach this question series through question C4a, when scoring this section it is very important to verify that the respondent has reported a duration of at least 3 months (C4=2 or 3, or C4a>=3 months) before summing the number of positive responses. If the respondent reached this question series through C4a and did not report a duration of at least 3 months (>=3 months) then the responses to questions C5, C6, C7/C8 are treated as negative and the specific phobia score is 0.

As in the MD section, using the results in table 3 respondents can be classified as either probable cases or probable non-cases based on whether or not they have a specific phobia score of one or more. Alternatively, respondents can be assigned the probability of caseness that corresponds to their specific phobia score. Note that respondents who denied the specific phobia stem questions or otherwise skipped out of the section prior to assessing the four symptoms in the specific phobia score receive a probability of caseness equal to zero.

D. Social Phobia (SoP)

Section D of the CIDI-SF is designed to classify respondents according to the criteria of DSM-IV social phobia and is similar to that of the specific phobia evaluation apart from the need for a social or performance situational context. It should be noted that criteria G (exclusions for fears that are a result of substance use, or which result from a general medical condition or another mental disorder) and H (the fear is unrelated to a general medical condition or mental disorder) are ignored.

The section begins by assessing the types of situations where unreasonably strong social anxiety might occur. Fears of this type are organized into six categories: public speaking (D1a), eating or drinking in the company of others (D1b), talking with a person (D1c), writing in the company of others (D1d), participating in a discussion (D1e), and

participating in a social gathering (D1f). If no social anxiety is endorsed (D2=2) the respondent is skipped out of the section and receives a probability of caseness equal to zero. Otherwise (D2=1), the question series goes on to evaluate the frequency of anxious response to the stimulus. If the respondent endorses a relatively infrequent response to the situation (D3=3 or 4 or 7) they are skipped out of the section and receive a probability of caseness equal to zero.

For those respondents who have endorsed an unusually strong social anxiety (D2=1) with a sufficiently high frequency of response to the stimulus (D3=1 or 2), the subsequent questions evaluate for how long the fears have been experienced (D4=2 or 3, or D4a>=3 months), whether they interfere significantly with the R's life (D5=1), whether they cause distress (D6=1), and whether the fears are excessive or unreasonable (D7=1 or D8=1).

The social phobia score (range 0-3) is calculated by summing the number of positive responses to questions D5, D6, D7/D8. However, because there is no skip-out for respondents who reach this question series through question D4a, when scoring this section it is very important to verify that the respondent has reported a duration of at least 3 months (D4=2 or 3, or D4a>=3 months) before summing the number of positive responses. If the respondent reached this question series through D4a and did not report a duration of at least 3 months (>=3 months) then the responses to questions D5, D6, D7/D8 are treated as negative and the social phobia score is negative.

Using the results in table 4, respondents can be classified as either probable cases or probable non-cases based on whether or not they have a specific phobia score of two or more. Alternatively, respondents can be assigned the probability of caseness that corresponds to their social phobia score. Note that respondents who denied the social phobia stem questions or otherwise skipped out of the section prior to assessing the four symptoms in the social phobia score receive a probability of caseness equal to zero.

E. Agoraphobia without History of Panic Disorder (AGO)

Section E of the CIDI-SF is designed to classify respondents according to the criteria of DSM-IV agoraphobia without history of panic disorder.

The section begins by assessing the occurrence of anxiety associated with being in places or situations from which escape might be difficult or in which help may not be available when panic symptoms occur. These situations fall into five categories: being in a crowd or standing in a line (E1a=1), being away from home alone (E1b=1), travelling alone (E1c=1), travelling in a bus, train or car (E1d=1), or being in a public place (E1e=1). If none of the situations are endorsed (E2=2) the respondent is skipped out of the section and receives a probability of caseness equal to zero. Otherwise (E2=1), the question series goes on to evaluate the frequency of anxious response to the stimulus. If the respondent endorses a relatively infrequent response to the situation (E3=3 or 4 or 7) they are skipped out of the section and receive a

probability of caseness equal to zero.

For those respondents who have endorsed one of the situations (E2=1) together with a sufficiently high frequency of anxious response to the situation (E3=1 or 2), the subsequent questions evaluate: for how long the fears have been experienced (E4=2 or 3 or E4a>=3 months), and whether it interferes significantly with the R's life (E8=1). In addition, questions E5, E6, and E7 evaluate the characteristic symptoms of agoraphobia: fear of fainting, loosing control, or embarrassing yourself (E5=1), fear of being trapped without escape (E6=1), and fear that help might not be available if it is needed (E7=1).

The agoraphobia score (range 0-4) is calculated by summing the number of positive responses to questions E5-E8. However, because there is no skip-out for respondents who reach the E5-E8 question series through question E4a, when scoring this section it is very important to verify that the respondent has reported a duration of at least 3 months (E4=2 or 3, or E4a>=3 months) before summing the number of positive responses. If the respondent reached this question series through E4a and did not report a duration of at least 3 months (>=3 months) then the responses to questions E5-E8 are treated as negative and the agoraphobia score is zero.

Using the results in table 5, respondents can be classified as either probable cases or probable non-cases based on whether or not they have a agoraphobia score of one or more. Alternatively, respondents can be assigned a probability of caseness that corresponds to their agoraphobia score. Note that respondents who denied the agoraphobia stem questions or otherwise skipped out of the section prior to assessing the duration and interference symptoms receive a probability of caseness equal to zero.

(Note: These questions have undergone changes in wording since the original NCS administration. Therefore, while an AGO score as high as 4 can be assigned, no one in the development sample scored higher than 1).

F. Panic Attack (PA)

Section F of the CIDI-SF is designed to classify respondents according to DSM-IV panic attack criteria.

The section begins by assessing whether a panic attack has occurred (F1=1). This is followed by a series of questions that evaluate exclusions for attacks that occurred as a result of: being in a life-threatening situation (F1a/F1b), being in danger or at the center of attention (F4), or being in a situation that usually provokes unreasonably strong fear (F5/F5a).

If the respondent does not report having experienced a panic attack (F1=5), or indicates that it only occurs in response to a life-threatening situation (F1b=5), or as a response to danger or being the focus of attention (F4=5), or that it occurs usually in situations that normally cause unreasonably strong fears (F5a=5), then they are skipped

out of the section and receive a probability of caseness equal to zero. If the respondent reports a panic attack and passes the exclusion criteria, then six symptom questions are asked: pounding heart (F6a=1), discomfort in the chest or stomach (F6b=1), sweating (F6c=1), trembling or shaking (F6d=1), hot flashes or chills (F6e=1), and sense of unrealness (F6f=1). The panic attack score (range 0-6) is calculated by summing the number of positive responses to these questions (F6a-f). Questions F2 and F3 are *not* used in the panic attack score.

Using the results in table 6, respondents can be classified as either probable cases or probable non-cases based on whether or not they have a panic attack score of three or more. Alternatively, respondents can be assigned the probability of caseness that corresponds to their panic attack score. Note that respondents who denied the panic attack stem questions or otherwise skipped out of the section prior to assessing the six symptoms in the panic attack score receive a probability of caseness equal to zero.

G. Alcohol Dependence (AD)

Section G of the CIDI-SF is designed to classify respondents according to criterion A of the DSM-IIIR alcohol dependence diagnosis.

The section begins by assessing whether the respondent has had at least four drinks during any single day in the last 12-months (G1=3 or 4 or 5) and then goes on to assess seven symptoms of DSM-IIIR alcohol dependence: role interference as a result of use (G2=1), use in hazardous situations (G3=1), emotional or psychological problems as a result of use (G4=1), strong desire or urge to drink (G5=1), a great deal of time using or recovering (G6=1), drinking more or using longer than intended (G7=1), drinking more to get the same effect (G8=1). If the respondent reports having less than 4 drinks during every day in the past 12-months (G1=1 or 2) or volunteers that they are a ‘casual/social drinker’ at any point in the question sequence, then they are skipped-out of the section and receive a probability of caseness equal to zero.

If the respondent reports having had at least 4 drinks during any one day in the past 12-months (G1=3 or 4 or 5) and has *not* volunteered that they are a ‘casual/social drinker’, then the alcohol dependence score (range 0-7) is equivalent to the number of positive responses to the seven symptom questions. Questions G2a and G7a are *not* used in the scoring.

Using the results in table 7, respondents can be classified as either probable cases or probable non-cases based on whether or not they have an alcohol dependence score of three or more. Alternatively, respondents can be assigned the probability of caseness that corresponds to their alcohol dependence score. Note that respondents who denied the alcohol dependence stem questions, volunteered they were ‘casual/social drinkers’, or otherwise skipped out of the section prior to assessing the seven symptoms in the alcohol dependence score receive a probability of caseness equal to zero.

H. Drug Dependence (DD)

Section H of the CIDI-SF is designed to classify respondents according to criteria A and B of the DSM-IIIR drug dependence criteria.

The section begins by assessing the types of drugs used in the past 12-months: sedatives (H1a=1), tranquilizers (H1b=1), amphetamines (H1c=1), analgesics (H1d=1), inhalants (H1e=1), marijuana (H1f=1), cocaine (H1g=1), LSD (H1h=1), and heroin (H1i=1). If any drug use was endorsed (H2=1) then the section goes on to assess seven symptoms of DSM-IIIR drug dependence: role interference as a result of use (H3=1), use in hazardous situations (H4=1), emotional or psychological problems as a result of use (H5=1), strong desire or urge to use (H6=1), a great deal of time spent using or recovering (H7=1), using more or longer than intended (H8=1), using more to get the same effect (H9=1). Otherwise, if the respondent reports no drug use in the past 12-months (H2=2) then they are skipped-out of the section and receive a probability of caseness equal to zero. The drug dependence score is equivalent to the number of positive responses to the seven symptom questions. Questions H3a and H8a are *not* used in the scoring.

Using the results in table 8, respondents can be classified as either probable cases or probable non-cases based on whether or not they have a drug dependence score of three or more. Alternatively, respondents can be assigned the probability of caseness that corresponds to their drug dependence score. Note that respondents who denied the drug dependence stem questions or otherwise skipped out of the section prior to assessing the seven symptoms in the drug dependence score receive a probability of caseness equal to zero.

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Table 1. Probability of caseness for DSM-IV Major Depression (MD).

Short Form MD Score	Probability of CIDI Caseness
0	0.0001
1	0.0568
2	0.2352
3	0.5542
4	0.8125
5	0.8895
6	0.8895
7	0.9083

Table 2. Diagnostic algorithm for DSM-IV Generalized Anxiety Disorder (GAD).

Short Form Criteria	Evaluation
Criterion A: stem	B3=1 and B4=1 and B5=1 and (B6=2 or B8=1)
Criterion B: difficult to control	B7=1 or B9=1 or B10=1
Criterion C: symptom count	Three (3) or more symptoms endorsed in B12a-g
Criterion D: diagnostic exclusion	exclusion criteria are not applied
Criterion E: clinically significant distress or impairment	implied by endorsement of criteria A and B
Criterion F: attribution to substance use or a general medical condition	not evaluated

Table 3. Probability of caseness for DSM-IV Specific Phobia (SpP).

Short Form SpP Score	Probability of CIDI Caseness
0	0.0059
1	0.6173
2	0.8078
3	0.9016

Table 4. Probability of caseness for DSM-IV Social Phobia (SoP).

Short Form SoP Score	Probability of CIDI Caseness
0	0.0000
1	0.0125
2	0.9220
3	0.9540

Table 5. Probability of caseness for DSM-IV Agoraphobia (AGO).

Short Form AGO Score	Probability of CIDI Caseness
0	0.0000
1	0.9958

Table 6. Probability of caseness for DSM-IV Panic Attack (PA).

Short Form PA Score	Probability of CIDI Caseness
0	0.000
1	0.1000
2	0.4175
3	0.8701
4	1.0000
5	1.0000
6	1.0000

Table 7. Probability of caseness for DSM-IIIR Alcohol Dependence (AD).

Short Form AD Score	Probability of CIDI Caseness
0	0.0003
1	0.0614
2	0.3874
3	0.8411
4	1.0000
5	1.0000
6	1.0000
7	1.0000

Table 8. Probability of caseness for DSM-IIIR Drug Dependence (DD).

Short Form DD Score	Probability of CIDI Caseness
0	0.0000
1	0.0492
2	0.2787
3	0.7561
4	1.0000
5	1.0000
6	1.0000
7	1.0000