PSYCHIATRIC DIAGNOSIS: RATER RELIABILITY AND PREDICTION

USING "PSYCHOLOGICAL RATING SCALE
FOR DIAGNOSTIC CLASSIFICATION"

DISSERTATION

Presented to the Graduate Council of the
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By

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This study was designed to assess the reliability of the "Psychological Rating Scale for Diagnostic Classification" as an instrument for determining diagnoses consistent with DSM-III criteria and nomenclature. Pairs of raters jointly interviewed a total of 50 hospital patients and then independently completed the 70-item rating scale to arrive at Axis I and Axis II diagnoses which were subsequently correlated with diagnoses obtained by standard psychometric methods. Interrater agreement was 88 per cent for Axis I and 62 per cent for Axis II, with correlations of .94 and .79 respectively. Correlations of rating scale diagnoses with psychometrically derived diagnoses yielded an overall rate of agreement of 91.33 per cent on Axis I and 80 per cent on Axis II. Despite lower reliabilities of Axis II diagnoses, both hypotheses of the study were supported at the .001 level of significance. As a reliable and objective interdisciplinary means of structuring, standardizing, eliciting, and evaluating patient information, the rating scale instrument could help ensure that variability among
clinicians in how they conduct interviews and in what topics they cover is kept to a minimum.
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While there appears to be some optimal level of information about characteristics of patients which produce maximum diagnostic agreement among clinicians, styles of observation, information gathering, and processing in diagnostic activity have varied greatly (Beck, 1962; Blashfield & Draguns, 1976; Clavelle & Turner, 1980; Frank, 1975; Katz, Cole, & Lowery, 1969). As noted by multiple reviews of the many systems, diagnostic classification of psychopathology has been traced to the earliest records of scientific data (Garside & Roth, 1978; Holzberg & Wittenborn, 1953; Jackson, 1970; Millon, 1975; Sharma, 1970; Zigler & Phillips, 1961). The diagnostic system presented in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (3rd ed.) has been described as the earmark of an advancement over simple observation and labeling.

The earliest known formal diagnostic system predated the well-known one of Hippocrates by 1000 years (Woods, 1979). This was a classification used in India in approximately 1400 B.C. which contained seven major categories of psychological disorders (Frank, 1975). In the fifth century B.C., Hippocrates divided mental disorders into five categories:
phrenitis, mania, melancholia, hysteria, and epilepsy (Millon, 1969). Depicting classifications in terms of symptoms and assumed etiology, the nomenclature of the Hippocratic writings reflected the Greek concept of disease origin within the patient or within his immediate surroundings (Veith, 1957). As noted by Veith (1957), it was Celsus, the "encyclopedist of ancient medicine" (p. 385), who ultimately organized Hippocratic disease concepts into a system which classified specific disease complexes and differentiated acute and chronic states.

In the sixteenth century, Fernel developed a classification system which correlated disease and bodily structure and subdivided diseases into general and specific types. At the turn of the seventeenth century, Platter developed a system whereby illness was considered a static condition to be classified by means of observable symptoms (Veith, 1957). Thus, the eighteenth century trend toward disease-oriented classification was based on the view that "close observation of symptoms would reveal an underlying disease entity" (Millon, 1969, p. 11). François Boissier de Sauvages likewise viewed symptoms as "just so many different diseases" (Veith, 1957, p. 388), and consequently his nosology contained 2400 different diseases grouped under 10 classes, 40 orders, and 78 genera.
It was Philippe Pinel, a student of Sauvages, whose clinical experience and associated extensive systematic observation of patients led him to develop a "nosographie to determine common elements in different cases of the same disease" (Veith, 1957, p. 388). Differing from his predecessors, Pinel's classification system simplified conceptions of insanity into five forms: mania with delirium, mania without delirium, melancholia, dementia, and idiotism. It was the effort to understand the basic principles and nature of mental disease by means of systematic observation of patients through all phases of their illness which constituted Pinel's major contribution to psychiatric nosology. Like Pinel, Jean-Martin Charcot valued a general kind of observation, more familiar perhaps to the ancients, which does not limit itself to an examination of isolated phenomena, but which regards them on the contrary in their mutual bearings, in their order of succession; in short, as Nature presents them to him who can get a bird's-eye view of things (Veith, 1957, p. 390).

As recounted by Frank (1975), Lord and Flemming ascertained the development of 19 different systems of classification in psychiatry from the period of 1845 to 1932. Millon (1969) described Kraepelin's classification system as being among the "most resilient and influential" (p. 12) in that he sought to "synthesize symptom pictures
and patterns of onset, course, and outcome by means of minute observation” (Millon, 1969, p. 12). According to Veith (1957), Kraepelin's clinical observations and close study of the life histories of his patients convinced him that "the principle requisite in the knowledge of mental disease was an accurate definition of the separate disease processes and the search for disease entities" (p. 391). It was such a task that characterized what began as Kraepelin's small compendium in 1883. Ultimately growing to a 2425 page text, in its 1927 ninth edition, Kraepelin's text classified mental diseases into 18 groups (Veith, 1957, p. 391). For Kraepelin, classification was inextricably related to etiology, treatment and prognosis (Frank, 1975; Zigler, 1961).

In the United States, although statistical data on mental illness was collected and published as early as 1840, there were no differential classifications between types of illness until 1880 (DSM-II, 1952, p. xi). In the Introduction of the DSM-II, Kramer reviewed the history and development of the classification of mental disorders in the United States and cited the following:

Much effort has been put forth to secure uniformity in the classification of the insane in every country of the world; but it seems impossible for those best qualified to form an opinion to agree upon any scheme which can be devised. Some classifications are based upon symptoms and some upon physical causes;
others are a mixture of the two; and still others take into account the complications of insanity. For the purposes of the census, it seemed to me advisable to disregard all minute subdivisions and to adopt a simple analysis on the broadest possible outlines. On consultation... it was decided to make but seven distinctions as to the form of insanity, namely: Mania..., melancholia..., monomania..., paresis..., dementia..., dipsomania... and epilepsy... (pp. xi-xii).

Between World War I and II, a system of 24 categories of classification was utilized in the United States (Frank, 1975; Woods, 1975). Identifying conditions underlying unreliability prior to the publication of DSM-I in 1952, Spitzer, Endicott, and Robins described psychiatric diagnostic practice as follows:

Until the 1950's, a clinician seeking guidance on the criteria for a given diagnosis was dependent on textbooks and individual articles in which typical cases were described and the author's own conception of the illness was explicated (p. 1188).

In 1952, the first edition of the Diagnostic and Statistical Manual of Mental Disorders was introduced, and contained the definitions associated with seven major categories of almost 100 specific diagnoses. In 1968, DSM-II was published and contained 100 specific diagnostic disorders grouped under ten categories: mental retardation, organic brain syndrome, psychosis, neurosis, personality disorder, psychophysiological disorder, transient situational disturbance, special symptoms, behavior disorders of childhood
and adolescence, and conditions without manifestation of psychiatric disorder (Frank, 1975).

Many researchers and clinicians have identified and discussed major differences between the 1952 and 1968 versions of the official American Psychiatric Association's system of classification (Beitchman, Dielman, Landis, Benson, & Kemp, 1978; Frank, 1975; Jackson, 1970; Mezzich, 1979; Nathan, 1967; Rosenhan, 1975). Among the major differences depicted by Frank (1975), in his review of the literature, were the following.

(a) The names of some of the disorders are modified.
(b) There is a general elimination of the term "reaction" thereby seeming to abrogate the conceptual modification made by Meyer, in favor of a return to the more Kraepelinian typology.
(c) The 1952 system has seven major categories, the 1968 ten.
(d) Involutional psychotic reaction has been moved (i.e., now included with) the section on major affective disorders, while psychotic depressive reaction is now a separate category.
(e) Changes have been made in the definition of several of the disorders.
(f) Recording of multiple psychiatric diagnoses is encouraged (p. 5).

Enumerating the multiple, longstanding complexities involved, and stating the belief that "there appears no end to the making of taxonomies" (p. 105), Jackson (1970) specifically identified multiple positive and negative features of the DSM-II. Among the major changes judged to
be advances were the following: elimination of the term reaction; greater recognition of the importance of time and associated "fluidity" of psychological disturbances; new nomenclature which enabled diagnosis of each perceived disorder; exclusion of the categories of personality trait disorder and personality pattern disorder; addition of explosive personality category; recognition of sexual deviation as symptoms or symptom complexes; use of drug dependence rather than drug addiction; and provision of a differential scheme for the diagnosis of mental retardation (pp. 107-108).

Acknowledging that the DSM-I for the first time provided the United States with standardized names, codes, and general guidelines for differential diagnoses, drafters of DSM-II mirrored the same approach while attempting to provide substantial improvements. Spitzer, Endicott, and Robins (1975) identified several reasons for the continued lack of high reliability which characterized both DSM-I and DSM-II:

The clinician is forced to rely heavily on his own concepts of the diagnostic categories because there are no formal definitions offered for most of them; features that are invariably present in the disorder are often not clearly distinguished from features that are commonly but not invariably present. In addition, there is often no clear indication of which features distinguish a particular condition from similar conditions. There are usually few, if any, guidelines as to which should be joint diagnoses to help the clinician faced with a patient with clinical features suggesting two different conditions.
Sometimes the classification forces the clinician to choose between competing classificatory principles without a rule as to which takes precedence. Frequently a classificatory principle is a function of tradition or of some hypothesized causal factor with little research evidence to support its validity. Finally, even when concepts are clearly presented, there are no operational rules that the clinician can apply to a given case to determine whether or not the criteria of a particular diagnostic category have been met (p. 1188).

In 1974, a Task Force on Nomenclature and Statistics was appointed by the American Psychiatric Association to develop the DSM-III. Concurring with the general view of DSM-II as being somewhat limited and unreliable, members of the DSM-III Task Force were concerned with achievement of the following objectives:

--clinical usefulness for making treatment and management decisions in varied clinical settings;
--reliability of the diagnostic categories;
--acceptability to clinicians and researchers of varying theoretical orientations;
--usefulness for educating health professionals;
--maintaining compatibility with ICD-9, except when departures are unavoidable;
--avoiding the introduction of new terminology and concepts that break with tradition, except when clearly needed;
--reaching consensus on the meaning of necessary diagnostic terms that have been used inconsistently, and avoiding the use of terms that have outlived their usefulness;
--consistency with data from research studies bearing on the validity of diagnostic categories;
--suitability for describing subjects in research studies;
--being responsive during the development of DSM-III to critiques by clinicians and researchers (DSM-III, 1980, pp. 2-3).
As stated in its Introduction: "The purpose of the DSM-III is to provide clear description of diagnostic categories in order to enable clinicians and investigators to diagnose, communicate about, study, and treat various mental disorders" (DSM-III, 1980, p. 12). According to Schacht and Nathan (1977), the scope of the DSM-III developmental process was based on the principle that whenever a clinical condition could be described with clarity and relative distinctness, it was evaluated for inclusion. Similarly reflective of the rationale and philosophy characterizing the lengthy development process of the DSM-III were numerous evaluative efforts and field trials. All such activities were aimed at identifying and resolving problem areas in the new classification system prior to the official adoption in 1979.

Schacht and Nathan (1977), in their appraisal of the final DSM-III draft and its accompanying guiding principles, aptly reiterated the overall objective of the DSM-III as the development of a classification system reflective of the "current state of knowledge regarding mental disorders" (p. 1019). Compared with its predecessors, the following were also identified as primary accomplishments of the DSM-III: redefinition of major terms and conditions, new categories, and a definition of mental disorder. In further describing the DSM-III, it was stressed that the inclusion
of multiaxial information relevant to treatment and prognosis demonstrably confronted the DSM-II problem of categorizing solely from symptoms. The DSM-III format provided for psychiatric conditions to be described first, and in so doing, previous problems of multiple diagnoses were perceived to be eased. While somewhat questioning of the operational nature of diagnostic criteria offered by DSM-III, Schacht and Nathan (1977) positively acknowledged the underlying rationale of increasing interrater reliability by specification of criteria as guidelines for diagnosis.

Somewhat globally depicted as "mechanisms for describing, in form amenable to further quantitative evaluation, the symptoms and signs upon which psychiatric diagnoses have traditionally been based" (Overall, Hollister, & Pichot, 1967, p. 17), rating scales have quantitatively recorded inferential judgments or direct observations about a particular trait or characteristic under study since ancient times. Having had their beginnings in European laboratories as quantifying devices for judgments of sensory and perceptual responses, actual progress in technique and adaptation of rating scales became most evident early in the twentieth century. During and after World War I, there was a period of rapid growth in social sciences and likewise in the use of rating scales and other quantifying methods, particularly in areas of prediction and decision-making in
Although utilization of rating scales and related quantitative devices for psychiatric purposes initially developed slowly, an early example of actual construction and application of such an instrument was the Phipps Psychiatric Clinic Behavioral Chart, used at Johns Hopkins over half a century ago. Because the use of most rating scale instruments devised during the 1920's and 1930's tended to be primarily local, their functions and applications were focused on specific research or management needs of particular settings. During and following World War II, however, widespread concern over mental health and illness, and the introduction of psychotropic drugs, led to increased interest in development of rating scales in psychopharmacology and clinical research in general (Handbook of Psychiatric Rating Scales, 1981).

During the last decade, rating scales were widely used in psychiatric diagnosis and research, primarily to increase reliability and objectivity (Cooper, Copeland, Brown, Harris, & Gourlay, 1977; Copeland, Kelleher, Gourlay, & Smith, 1975; Duckworth & Kedward, 1978). One such scale was the Present State Examination originally developed for use by psychiatrists with patients with obvious mental illness, and subsequently employed in an effort to standardize clinical interviews and the rating of psychiatric symptoms.
among a wide variety of settings and interviewers (Cooper et al., 1977).

The associated diversity of psychiatric rating scales appeared substantial in regard to population, setting and raters. Scales existed for rating children and adults, for application to specific settings or wide segments of society, and for use by various kinds of both professional and lay observers. For example, psychiatric rating scales described in the 1981 Handbook of Psychiatric Rating Scales have been applied to areas such as the following:

1. Predicting the effects of a drug in a specific type of schizophrenia.
2. Identifying "types" of depression and schizophrenia.
3. Problems in investigating the meaning and process of diagnosis.
4. Assessing the impact of psychological treatments.
5. Providing a base for automating hospital record systems.
7. Exploring the influence of culture on shaping psychosis (p. v).

As discussed by Overall, Hollister, and Pichot (1967), psychometricians differed considerably over the desirable level of abstraction in rating scales. Diagnosticians who believed that abstract concepts could not be evaluated reliably stated that the appropriate function of psychiatric rating scales was to minimize the role of clinical judgment by providing enumeration of discrete, molecular, behavioral
characteristics. Overall et al. (1967), adhering to a different view, demonstrated significant reliability and validity of so-called abbreviated scales to characterize global psychopathological manifestations.

Unquestionably, the nature and variety of symptoms found in psychiatric patients, coupled with the multiple variables which potentially influenced the degree of interdiagnostician reliability, have made diagnosis a formidable task. According to Overall and Hollister (1964), the development of a rating scale measurement device as a quantitative procedure for classification of psychiatric patients necessarily involved three distinct phases:

1. Definition of the measurement space,
2. Definition of diagnostic types within the measurement space, and
3. Specification of objective decision procedures for classifying each patient into one and only one of the multiple classes on the basis of his objectively measurable symptoms (p. 583).

In the attempt to define diagnostic types quantitatively in terms of objective symptom measures, Overall and Hollister (1964) began with current psychiatric diagnostic nomenclature, which they assumed to be founded in "the empirical sifting of decades of clinical experience" (p. 584). Resultant development of their Brief Psychiatric Rating Scale provided a measurement device for the quantitative description of patients on the basis of objective symptom ratings, and led to development of quantitative procedures
for patient evaluation and diagnosis which were later programmed for computer application.

In 1951, Wittenborn undertook a series of studies in an effort to devise a rating scale intended to serve as a reliable and valid psychiatric diagnostic rating device (Wittenborn & Holzberg, 1951; Wittenborn & Mettler, 1951). Wittenborn asserted that for diagnostic procedures based on rating scales to function as anticipated and intended, certain safeguards required careful consideration. Succinctly reflecting some tenets and precautions deemed basic to rating scale development, Wittenborn (1951) stressed the following.

1. The rating scales must sample adequately the important symptoms in mental hospital patients.
2. The rating scales must be restricted to currently discernible behavior so that their repeated use can reveal changes in the patient.
3. The scales must provide ratings which are relatively independent of the insights and sophistication of the rater.
4. The rating scale must provide ratings which are relatively independent of a bias or theoretical persuasion of the rater.
5. The rating scales must be of such form that each scale can be checked for every patient.
6. The rating scale must be feasible in so far as they draw upon behavioral features which are likely to be known or may be readily ascertained.
7. The rating scale must be simple in form and economical and convenient to use.
8. The rating scale must be in a form which does not bias the result of any analysis based upon them.
9. The rating scale must be reliable (pp. 290-292).
In identifying symptom configuration descriptions as a critical phase of psychiatric classification, Hoizberg and Wittenborn (1953) emphasized the significance of identifying criteria of behavior based on objectification and quantification of symptoms and facts rather than "speculation" and "etiology" (p. 147). Results of a series of studies on symptom description and diagnosis yielded the following generalizations by Hoizberg and Wittenborn (1953).

(a) There are consistent systematic symptom differences between patients who have been placed in the various diagnostic categories.

(b) Many symptoms characterize more than one diagnosis and accordingly the symptom patterns for the diagnostic groups are not mutually exclusive.

(c) Because of the numerous and conspicuous exceptions to any diagnostic stereotype, the descriptive diagnoses are insufficient to the purpose of providing a dependable description of the symptom pattern of any particular individual (pp. 145-146).

The above generalizations characterized multiple quantitative evaluations of patients and formed the basis for Wittenborn's development of a rating scale procedure for the description of psychiatric patients. A given patient was thus evaluated according to the degree to which he or she resembled each of nine symptom groups represented by clusters of 55 rating scale items. Norms were subsequently established in order to produce a "quantified multiple diagnostic profile" (p. 146) which essentially indicated the
...diagnostic stereotype which the patient most resembled and the respects and the degree to which the patient departed from this and manifested characteristics of the other eight diagnostic stereotypes (Holzberg & Wittenborn, 1953, p. 146).

The authors cautioned that the rating scale process was not devised as a substitute for traditional personality studies of patients, but was a procedure designed to efficiently supplant the usual descriptive diagnosis.

Among the considerations cited by Holzberg and Wittenborn (1953) as supportive of the quantified rating scale procedures for obtaining diagnoses were the following:

(1) economy of description by reduction of many diagnoses to nine clusters of symptoms;
(2) breadth of description of each patient in terms of nine rather than one diagnostic stereotype; and
(3) achievement of 'less overlapping' of symptoms by empirically determining and weighting the symptoms which belonged together in clinically demarcated entities (p. 146).

In studies conducted to compare results of traditional psychiatric diagnoses and their quantified procedure, the authors stressed that:

...psychiatrists' diagnoses were descriptively insufficient and sometimes disregarded important and systematic differences among patients, whereas the multiple diagnostic procedure did reveal these differences (p. 146).

Thus, more adequate control of multiple, complex factors inherent in the diagnostic process resulted from utilization of a quantified psychiatric classification procedure.
According to Blashfield and Draguns (1976), taxonomy, classification and identification were the specific areas into which the general study of classification systems was divided. While taxonomy referred to the theoretical study of classification, classification more specifically referred to "the process of forming groups from a large set of entities or units" (p. 140). The product of the classification process was a classification system which comprised a well-defined set of entities. In psychopathology, diagnosis and identification have been synonymous in their reference to the process of "assigning an entity to a category in an already existing classification system" (p. 141). As depicted by Blashfield and Draguns (1976), the clients or patients were the entities classified.

Despite the various complexities and changes in diagnostic classification systems over the years, diagnoses have continued to function as shorthand statements to communicate information about patients. As noted by Frank (1975),

Diagnosis is essentially the old familiar scientific process of classification, of introducing order into one's observations, with an attendant increase in meaningfulness. . . . It is the labeling of an object or phenomenon in order to indicate its inclusion in a class of similar objects. . . . By placing the object in a certain class, it is possible to infer on the basis of this class membership possession of certain class characteristics by the object without the necessity of further
experience of it. Diagnoses are carriers of information... They should be evaluated in terms of economy with which they transmit information, the extent and accuracy of the information transmitted, and functional importance or relevance of this information... (p. 6).

Copeland, Kelleher, Gourlay, and Smith (1975) described the process of diagnosis as a logical sequence which encompassed four essential steps. The authors summarized each stage of the sequence in the following terms:

(1) the initial perception of the patient's behavior; (2) a judgment as to how far that behavior departs from the observer's concept of normality—that is, whether it is pathological, bearing in mind the patient's environment at the time and his intellectual and cultural background; (3) applying a technical term to the abnormal behavior according to a standard definition so that it is characterized as a symptom; (4) recognizing from the resulting collection of symptoms a pattern which is characteristic of a particular syndrome or illness (p. 89).

Although the DSM-III signified an effort aimed at more adequate, systematic control of complex factors inherent in the diagnostic process, continued unreliability of psychiatric diagnoses may lie in the variability of the operations by which clinicians have evaluated and used observations from interview data. In describing the varying forms which diagnostic unreliability has taken, Nathan, Andöberg, Behan, and Patch (1969) cited the following:

Clinicians may for example differ among themselves in a diagnostic formulation even when it is based upon the same set of diagnostic information because
of their own personal, often idiosyncratic interpretations of these data. In addition, a single diagnostician may label essentially the same set of behavioral pathology differently on different occasions because he does not use a constant set of decision rules to integrate the data. Finally, low diagnostic reliability may result from the fact that patients who share common psychopathology often manifest the same symptoms with such significant differences in frequency and intensity that their common diagnoses are lost (p. 9).

The Psychological Rating Scale for Diagnostic Classification was developed according to DSM-III nomenclature and criteria as a means of increasing the precision and reliability of multiaxonal diagnoses. Additional refinements and extensions of clinical practice, education, training and research which could possibly result from employment of such a diagnostic rating scale device include: (1) increased breadth and uniformity of descriptions of patient symptomatology and diagnoses; (2) interdisciplinary consistency regarding diagnostic terminology, clinical assessment guidelines, and associated treatment planning; (3) a means of quantified study of the conditions under which symptom patterns may change; (4) quantified evaluation of certain therapeutic procedures; (5) validation of many diagnostic implications of psychological tests; and (6) a validation of many prognostic uses made of test scores. Although this brief list does not exhaust possible uses of such a diagnostic procedure, it is sufficient to indicate potential advancements which
could accrue from utilization of the "Psychological Rating Scale for Diagnostic Classification."

The purpose of the present study was to establish the "Psychological Rating Scale for Diagnostic Classification" as a systematic means of patient evaluation in which specific symptomatology clusters were observed and objectively rated. Diagnostic rules based on DSM-III were subsequently applied to ratings of observed patient characteristics to derive a multiaxonal diagnostic differentiation consistent with DSM-III criteria and nomenclature. As a means of structuring both the accumulation of data and its statistical analysis and to provide an a priori basis for decisions regarding significance of results, two hypotheses were formulated. First, it was hypothesized that there would be a significant positive correlation between diagnostic classifications derived by independent raters using the "Psychological Rating Scale for Diagnostic Classification." The second hypothesis was that there would be a significant positive correlation between diagnostic classifications resulting from use of the "Psychological Rating Scale for Diagnostic Classification" and the diagnostic classifications determined by criteria of a standard, clinical interview and psychometric evaluation (Wechsler Adult Intelligence Scale, Minnesota Multiphasic Personality Inventory, Sixteen Personality Factor Test, Millon Behavioral Health Inventory, Critical Life Incidents Checklist, Cornell Index).
Method

Subjects

The 50 subjects included in this study were drawn randomly from newly admitted adult (18+ years) patients at three private, community hospitals in Houston, Texas. No restrictive criteria for inclusion, other than in-patient status and the minimum age requirement, were employed.

Instrument

The instrument utilized as the basis for the present study was the "Psychological Rating Scale for Diagnostic Classification" (see Appendix A). The term diagnostic was used in a limited, descriptive sense with each of the rating scale items being drawn from specified DSM-III criteria, tested for commonality of meanings among graduate psychology students, and factor analyzed to determine appropriate symptom grouping and statistical weight. Accordingly, the focus of the diagnostic rating scale instrument was not with etiology, prognostic or dynamic considerations, but with accurate recognition, observation and labeling of phenomena which characterized the patient. Initial reliability studies with graduate students in psychopathology using the instrument to rate case vignettes yielded significant levels of agreement among raters regarding presence or absence of characteristics as well as major diagnostic categorizations ($r = .84 - .95$).
The "Psychological Rating Scale for Diagnostic Classification" provided a quantified method for description of patients, and indicated the degree to which individuals' observable symptom manifestations or direct verbalizations resembled diagnostic classifications consistent with the DSM-III. The 70 item instrument briefly and non-technically described indicators of psychopathology symptoms and specifically indicated how each was to be coded.

Utilization of the instrument required that the rater compare the patient with each of the 70 items and record his decision as to whether the symptom was present by making checkmarks in indicated columns beside each item. It was subsequently possible to score ratings for each patient with respect to all of the items by tallying checkmarks in adjacent columns.

Specified cutting points for category ratings identified the patient as having either "some evidence" or "substantial evidence" of a specific syndrome. On the basis of scoring data, a profile was obtained which indicated the degree to which the patient's symptom manifestations resembled each of the nine following major diagnostic classifications:

Axis I - Organic Mental Disorder, Substance Use Disorder, Psychosis, Paranoid Disorder, Affective Disorder, Anxiety Disorder, Somatoform Disorder, Dissociative Disorder, and Axis II - Personality Disorder.
Raters

Three Ph.D. staff psychologists, one advanced level psychology intern, and three master's level psychologists served as raters in the study. The four male and three female raters varied in age, background, and theoretical orientations. None of the raters had had previous experience with the instrument, though all were knowledgeable and experienced in utilization of DSM-III for purposes of diagnostic classification of adults.

Procedure

Raters participated in three one-hour training sessions to minimize individual differences in interviewing techniques as related to coherent observation, descriptive classifications, and diagnostic procedures. During training sessions participants reviewed the Psychological Rating Scale for Diagnostic Classification and its diagnostic guidelines (see Appendix B), practiced rating sample cases, and discussed criteria of the various diagnostic categories. This training procedure was employed in an attempt to insure that all raters shared a common familiarity with, and understanding of, the rating scale items. After training was completed, raters were instructed not to discuss their ratings or diagnoses with each other during the study.

Raters were randomly paired so that each of the patients was seen by two different diagnosticians. Interviewing was
arranged so that each interviewer/observer pair (1) saw approximately the same number of Subjects, (2) utilized the rating scale approximately the same number of times, and (3) acted as both interviewer/examiner and observer/rater on an approximately equal number of different occasions. The procedure was to have one diagnostician interview the patient, while the other acted as a silent observer/rater. Following the clinical interview, each diagnostician independently completed the rating scale and accordingly determined his diagnostic conclusions. Both raters utilizing the research instrument made judgments regarding presence, absence, and severity of symptoms based on interview content, and accordingly separate multiaxonal diagnoses were derived.

Results

The age range of the 34 female and 16 male patients participating in the study was from 19-65 years, and the ethnic-racial distribution was as follows: white, not of hispanic origin (80%), hispanic (2%), black, not of hispanic origin (16%), and other (2%). The interrater reliability for the diagnostic classes represented in the patient sample, as well as the overall agreement between rating scale diagnoses and psychometric diagnoses, were examined by computing Phi-coefficients of correlation and percentages of agreement.
As presented in Table 1, interdiagnostician agreement using the "Psychological Rating Scale for Diagnostic Classification" yielded correlations of .94 for Axis I and .79 for Axis II, and was significant at the .001 level.

Table 1

Interrater Reliability and Percent of Agreement for Rating Scale Diagnostic Classification

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<th>DSM-III</th>
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<th>Percent Agreement</th>
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<tr>
<td>Axis I</td>
<td>.94</td>
<td>88</td>
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<tr>
<td>Axis II</td>
<td>.79</td>
<td>62</td>
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When the diagnoses resulting from traditional psychometric methods were compared to those determined from utilization of the rating instrument by pairs of independent raters (see Table 2), correlations were of .98 (96%) and .95 (90%) for Axis I and .90 (82%) and .86 (74%) for Axis II. Results presented in Table 2 are significant at the .001 level, indicating an overall diagnostic agreement rate of 91.33% on Axis I and 80% on Axis II.
Table 2

Diagnostic Classification: Correlation and Percent Agreement Between Rating Scale Instrument and Psychometric Criteria

<table>
<thead>
<tr>
<th>DSM-III</th>
<th>Rater 1</th>
<th>Rater 2</th>
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<tr>
<td>Axis</td>
<td>r</td>
<td>%</td>
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<tr>
<td>I</td>
<td>.98</td>
<td>96</td>
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<tr>
<td>II</td>
<td>.90</td>
<td>82</td>
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Discussion

In an investigation of the reliability of the "Psychological Rating Scale for Diagnostic Classification," a series of 50 hospital patients were interviewed by paired raters and independently diagnosed according to standard DSM-III criteria. The significant positive correlations between diagnostic classifications derived by raters, as well as between the rating scale diagnoses and psychometrically determined diagnoses, supported both hypotheses of the study.

Without questioning whether clinical diagnosis was valid or invalid, statistical analysis of results revealed the "Psychological Rating Scale for Diagnostic Classification" to be an adequate instrument for evaluating essential
differences among diagnostic types and yielding diagnoses consonant with DSM-III. It was also demonstrated that diagnostic classifications based upon objective profile ratings from the instrument significantly and positively correlated with traditional psychometrically derived diagnoses. Were the attained indices of agreement to be used to estimate the validity of this new diagnostic technique, they would show that the validity of the rating system approached the reliability of it.

The implications for utilization of the "Psychological Rating Scale for Diagnostic Classification" method for diagnostic classification appear multiple and varied. Because it contains precoded items and procedural guidelines which specifically define the behaviors to be rated, it appears feasible that with proper training, allied health professionals familiar with psychiatric patients and their problems could reliably utilize the rating scale. The structural characteristics of the rating scale also suggest its potential utility for multidisciplinary diagnostic training purposes or for experienced professionals not yet sufficiently familiar with DSM-III nomenclature and criteria.

There seems a tendency for some clinicians to arrive at a diagnosis too quickly when faced with highly salient patterns which may in fact represent another diagnosis. An apparent advantage in the utilization of the "Psychological
Rating Scale for Diagnostic Classification" is the breadth of item description used to define the various classifications. By employing the rating scale instrument in the diagnostic process, the various approximate paths will be systematically ruled out in the process of determining a more specific DSM-III oriented classification.

Results of this study, like results obtained in initial DSM-III field trials (Spitzer, Forman, & Nee, 1979) and the numerous studies cited by Beck et al. (1962), found interrater agreement on Axis II diagnoses to be lower than for Axis I. It appears that Axis II rating scale items and procedural guidelines for diagnosis may require greater clarity and specificity in order to enhance the levels of interrater agreement and correlations with psychometric data. Subsequent investigation of the means by which the rating scale instrument can more reliably depict, assess, and diagnose personality disorders seems warranted.

Additional studies which more stringently test interrater reliability in terms of agreement between raters on each of the 70 symptom categories for each subject could indicate whether specific individual items consistently give rise to particularly marked or frequent disagreements. Raters could also be requested to keep notes on those behaviors which they found difficult to code, in order to further indicate areas of possible improvement in the rating instrument or its procedural guidelines.
Appendix A

Psychological Rating Scale for Diagnostic Classification

to be used with DSM-III

Instructions

1. Assess the major problematic symptoms of the clients.
2. Place a check mark in the empty box or boxes corresponding to the appropriate statement on the form.
3. Total the check marks in each column (A - I).
4. Turn to the summary page and determine if the total check marks in a column (A - I) indicate some evidence or substantial evidence of a particular clinical syndrome.
5. If there is substantial evidence of a clinical syndrome, e.g., psychosis (c), check the accompanying booklet to determine the specific type of psychosis.
Appendix A—Continued

INTERPERSONAL RELATIONSHIPS:

1. Avoidance of others, socially or otherwise.

2. Involvement in excessive activities that have a high potential for painful consequences which are not recognized (e.g., buying sprees, sexual indiscretion, reckless driving, foolish business investments, etc.).

3. Exhibition of poor judgment and/or impulse control and apparent disregard for conventional rules of social conduct (e.g., coarse language, shoplifting, inappropriate jokes, etc.).

4. Extreme suspiciousness or jealousy of family or strangers and belief that others are out to persecute, deprive, deceive, or punish the individual without known, factual basis for these beliefs.

5. Hypersensitivity, such as being easily threatened, quick to take offense, etc.

6. Absence of warm, tender feelings for others and indifference to others in general.

7. History of continuous and chronic antisocial behavior (e.g., lying and stealing indiscriminantly, oppositional or aggressive behavior, etc.).
8. Generally passive, dependent on others, easily manipulated, will not make decisions for self, lacks self-confidence.

9. Expression of hostility is indirect (e.g., "forgetting" intentional inefficiency, procrastination, stubbornness dawdling, etc.).

10. Appearance of being cold, objective, unemotional, lacking in sense of humor.

11. Behavior is overly dramatic, reactive, intensely expressed (generally to draw attention); person usually lacking in genuineness (most commonly attractive seductive females).

12. Grandiose sense of self importance for uniqueness; preoccupation with fantasy of unlimited success; constant attention needs; interpersonal exploitativeness; lack of empathy.

13. Hypersensitivity to potential rejection, humiliation, or shame; an unwillingness to enter into relationships unless given unusually strong guarantees of uncritical acceptance; social withdrawal, but desire for acceptance.
14. Perfectionistic, insists that others submit to his or her way of doing things, excessive devotion to work and productivity to the exclusion of pleasure; very indecisive.

15. Generally encounters difficulty making decisions without assistance or advice from others.

16. Socially inappropriate, peculiar behavior, (e.g., talking to self in public, hoarding food, collecting garbage, etc.).

17. Deterioration and impairment from a previous level of functioning with regard to social relations and work performance.

18. Existence within an individual of two or more distinct personalities, each of which is dominant at one time (multiple personalities).

19. Poor adjustment in a variety of areas, involving intense and unstable interpersonal behavior, unstable mood (normal to dysphoria), poor self image; impulsive and unpredictable behavior that is potentially self-damaging (e.g., sex, gambling, suicide attempts); chronic feelings of emptiness, loneliness, boredom.
INTELLECTUAL AND MEMORY FUNCTIONING:

20. Frequently forgets phone numbers, conversations, other personal information.

21. Suddenly cannot recall important personal information that is too extensive to be explained by "forgetfulness" (amnesia).

22. Encounters excessive difficulty learning or remembering new material.

23. Intellectual difficulties that keep him or her from performing a job or daily routine adequately.

24. Impairment of abstract thinking, judgment, or other cortical functions (e.g., dysnomia-inability to name objects, dysgraphia-inability to write, aphasia, etc.).

25. Easily distracted, unable to maintain attention to external and internal stimuli, disordered stream of thought.

26. Extreme illogical thinking, or loosening of associations (e.g., ideas that shift from one subject to another in a bizarre, unrelated fashion).
PERCEPTUAL INVOLVEMENT:

27. Evidence or reports of hallucinatory experiences (i.e., he or she sees, hears, feels, etc., things which are not really present).

28. Delusions - unreasonable or exaggerated beliefs and ideas that have little or no basis in fact, but do follow a coherent theme.

29. Experiences fragmentary delusions or hallucinations that do not follow a coherent theme.

30. Experiences unusual perceptions, such as recurrent illusions, sensing the presence of a force or person not actually present.

31. Bizarre ideation present, or magical thinking (e.g., superstitiousness, clairvoyance, telepathy, "sixth sense", etc.).

32. Delusions related to "thought broadcasting" (others can hear thoughts), thoughts are "inserted" into head by others, actions are "controlled" by others, etc.

33. Grandiose delusions and ideations, such as inflated self worth; belief that one possesses special power, knowledge, identity, or special relationship to deity or famous person.
34. Apparent withdrawal from the external world and preoccupation with egocentric and illogical ideas and fantasies.

35. Depersonalization - an alternation in the perception or experience of the self so that the usual sense of one's own reality is temporarily lost or changed (e.g., sensation that one's extremities have changed in size, perceiving oneself from a distance).

**SUBSTANCE USE:**

36. Recent ingestion of a substance such as alcohol, barbiturates, opioids, amphetamines, PCP, hallucinogens, cannabis, etc., (note the substance).

37. Inability to cut down or stop use of a substance which has been used continuously for at least one month (note substance).

38. Injection and use of a substance has lead to repeated conflicts with family, friends, job performance, etc. (note substance).

39. Withdrawal - recently stopped or reduced consumption of a substance that was regularly used for a considerable period of time (note substance).
### AFFECTIVE BEHAVIOR:

40. Affective responses are blunt, flat, and generally less intense than the situation requires.

41. Affective responses are inappropriate to the situation, such as giggling or laughing while talking of a problem.

42. Expresses and shows apathy and indifference in usual hobbies or previously enjoyable activities.

43. Exhibits emotional lability, such as explosive temper outbursts, sudden crying, etc.

44. Behavior is basically hostile, irritable, aggressive, short-tempered, complaining, etc.

45. Thinks of problems as unsolvable, situation as hopeless, feels sad, blue, "down in the dumps".

46. Has recurrent thoughts, plans, or attempts at suicide.

47. Predominant mood is excessively "elevated", cheerful, excited.

### PHYSICAL OR MEDICAL CONCERNS:

48. Movements are unusually slow, lethargic, fixed, indifferent, etc.
49. Complains of continuous fatigue, even when gets plenty of sleep.

50. Has severe insomnia when sedatives are not used (less than 4 hours of sleep in 24 hours).

51. Motor disturbance in the form of stereotyped, repetitive motor movements not apparently influenced by external stimuli.

52. Extreme motor disturbance, appearance of "stupor", maintains a rigid posture, or exhibits excited, purposeless motor activity.

53. 12-14 physical symptoms which are presented in a vague, exaggerated way and have no demonstrable organic findings; there is evidence, or a strong presumption, that the symptoms are linked to psychological factors.

54. A physical condition with demonstrable organic pathology or known pathophysiological process (e.g., headache, ulcer, asthma, etc.) that is initiated and/or exacerbated by psychological factors.
55. Unrealistically interprets physical signs or sensations as abnormal, leading to the preoccupation with the fear or belief of having a serious disease, though these fears or beliefs are not medically supported.

56. Severe and prolonged pain or loss of or alteration in physical functioning that suggests physical disorder (e.g., paralysis, seizures, blindness, etc.) but which instead is apparently an expression of a conflict, need, avoidance of activity, way to get emotional support, etc.

57. Evidence, from the history, physical exam or laboratory tests, of a specific organic factor judged to be etiologically related to the disturbance.

58. Experiences poor appetite or significant weight loss (when not dieting) or increased appetite and significant weight gain.

59. Exhibits poor hygiene, unkempt appearance because of indifference.

60. Restlessness, constantly moving, encounters difficulty remaining still and listening to others.
Appendix A—Continued

SPEECH:

61. Odd speech (without loose associations or incoherence) i.e., speech that is digressive, vague, over-elaborated, circumstantial, metaphorical.

62. Speech is pushed, rambling, hurried, or pressured, as if experiencing "racing thought".

63. Speech is excessively slow, shallow, and noncommittal.

64. Words used in an irrelevant, confusing, repetitive, illogical manner, making speech incoherent and difficult to understand.

ANXIETY AND/OR FEARS:

65. Has irrational, unreasonable, excessive fears of specific objects, activities, situations, animals, etc., that are troublesome to the individual and disrupt daily routines.

66. Persistent, generalized anxiety as evidenced by motor tension (shakiness, jitteriness) autonomic hyperactivity (sweating, heart pounding), apprehensive expectation (worry, fear, rumination), vigilance and scanning (distractibility, impatience).
67. Has recurrent, persistent ideas, thoughts, impulses, or images that are clearly excessive and are not felt to be under his or her control, such as repetitive thoughts of violence toward someone, being infected with germs, etc. These obsessions interfere with social functioning or daily routines.

68. Compulsions - individual has repetitive and seemingly purposeful behaviors that are performed according to certain rules or in a stereotyped fashion such as excessive handwashing, counting, checking, and touching.

69. Experienced a psychologically traumatic event outside the range of usual human experience, (e.g., rape, military combat, fires, earthquakes, etc.) and reexperiences this event through stressful, recurrent recollection, nightmares, etc.

70. Has excessive feelings of "guilt", sinfulness, self-blame, etc.

Total number of symptoms under each letter.
### SUMMARY PAGE

#### AXIS I

<table>
<thead>
<tr>
<th>Clinical Syndrome</th>
<th>Organic Disorders</th>
<th>Substance Abuse</th>
<th>Psychosis</th>
<th>Paranoid</th>
<th>Affective</th>
<th>Anxiety</th>
<th>Somatoform</th>
<th>Dissociative</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
<td>F</td>
<td>G</td>
<td>H</td>
<td>I</td>
</tr>
</tbody>
</table>

#### Evidence
- **Some Evidence**: 5+ 3+ 5+ 3+ 4+ 2+ 0 0 2+
- **Substantial Evidence**: 7+ 4+ 10+ 4+ 6+ 3+ 1+ 1+ 3+

#### Axis III: Presence of Medical History
- With possible related symptoms
- With definite supportive medical findings

#### Axis IV: Rating of Severity of Psychosocial Stressor
- 1 - None
- 2 - Minimal
- 3 - Mild
- 4 - Moderate
- 5 - Severe
- 6 - Extreme
- 7 - Catastrophic
- 0 - No Information

#### Axis V: Highest Level of Adaptive Functioning Last Year
- 1 - Superior
- 2 - Very good
- 3 - Good
- 4 - Fair
- 5 - Poor
- 6 - Very Poor
- 7 - Grossly Impaired
- 0 - No Information

* The numbers listed under the letters above represent either some evidence, e.g., (A) 5+ symptoms or substantial evidence, e.g., (A) 7+ symptoms.
Appendix B

Psychological Rating Scale for Diagnostic Classification
Procedural Guidelines for Coding

SUBSTANCE USE DISORDERS

A. **Substance Abuse**: #36, #37, and #38
   Name substance: alcohol, barbituates, or similarly acting sedatives or hypnotics, opioids, amphetamines or similarly acting sympathomimetics, cannabis.

B. **Substance Dependence**: #39 Tolerance (Markedly increased amounts of the substance are required for the desired effect.) Use same substance as listed above.

**Course** (5th digit)

1. **Continuous** (more than 6 months)
2. **Episodic** (circumscribed period of maladaptive use)
3. **In remission** (previous maladaptive use)
0. **Unspecified** (course unknown)

1. **ALCOHOL ABUSE**: Meets criteria of Substance Abuse 305.0X
   -- duration of at least 1 month
   -- pathological alcohol use causing maladaptive behaviors such as #17, #44, #5, etc.

2. **BARBITUATE OR SIMILARLY ACTING SEDATIVES OR HYPNOTICS ABUSE**: 305.4x
   -- meets criteria of Substance Abuse
   -- pathological use causing maladaptive behaviors such as #17, #44, #5, etc.
   -- duration at least 1 month

3. **BARBITUATE (OR SIMILAR DRUG) DEPENDENCE**: 304.1x
   -- meets Substance Dependence criteria
4. **OPIOID ABUSE:** Meets criteria for Substance Abuse
   305.5x — duration at least 1 month
   — pathological use causing maladaptive behavior such as #17, #44, #5, etc.

5. **OPIOID DEPENDENCE:**
   304.0x Meets criteria for Substance Dependence

6. **COCAINE ABUSE:** Meets criteria for Substance Abuse
   305.6x — duration of at least 1 month
   — pathological use causing maladaptive behavior

7. **AMPHETAMINE OR SIMILARLY ACTING SYMPATHOMIMETICS ABUSE:**
   305.7x Meets criteria for Substance Abuse
   — at least 1 month duration

8. **AMPHETAMINE (OR SIMILAR DRUG) DEPENDENCE:**
   304.4x Meets criteria for Substance Dependence

9. **PCP ABUSE:** Meets criteria for Substance Abuse
   305.9x — duration at least 1 month

10. **HALLUCINOGEN ABUSE:**
    305.3x Meets criteria for Substance Abuse
    — duration at least 1 month

11. **CANNABIS ABUSE:**
    305.2x Meets criteria for Substance Abuse
    — duration at least 1 month

12. **CANNABIS DEPENDENCE:**
    304.3x Meets criteria for Substance Dependence

13. **TOBACCO DEPENDENCE:**
    305.1x Meets criteria for Substance Dependence
    — duration at least 1 month
    — at least 1 unsuccessful attempt to quit, withdrawal symptoms, individual uses tobacco despite serious physical disorder

14. **OTHER, MIXED (MORE THAN 1) OR UNSPECIFIED (UNKNOWN) SUBSTANCE ABUSE:**
    305.9x Meets criteria for Substance Abuse
    — substance such as glue

15. **OTHER SPECIFIED SUBSTANCE DEPENDENCE:**
    304.6x e.g., codeine
Appendix B—Continued

16. **UNSPECIFIED**
   304.9x

17. **COMBINATION OF OPIOID AND OTHER NONALCOHOLIC SUBSTANCE**
   304.7x

18. **COMBINATION OF SUBSTANCES EXCLUDING OPIOID AND ALCOHOL**
   304.8x

**PSYCHOSIS**

A. **SCHIZOPHRENIA:** #17 and at least 1 of the following during a phase of the illness: 1) #28 2) #32 3) #27 4) #26 5) #4 6) #33 7) #63 with 40, 41 or 52

   -- continuous signs of illness at least 6 months
   -- no predominant affective disorder
   -- not due to MR, OBS
   -- onset prior to age 45

**OPTIONAL PHASES:**
1. Prodromal (deterioration in functioning prior to illness)
2. Residual (persistence of symptoms after illness)

At least 2 of the following for either phase: 1) #17 2) #1 3) #16 4) #59 5) #40 and/or 41 6) #61 7) #31 8) #30

**TYPES OF SCHIZOPHRENIA:**

255.1x **DISORGANIZED** (HEBEPHRENIC): Predominant features: #29, #64, #40 or 41

295.2x **CATATONIC:** Predominant feature: #52

295.3x **PARANOID:** Predominant features: #27 or 28 with #4, #33

295.9x **UNDIFFERENTIATED:** Not any of the above listed types or meets criteria for more than one

295.6x **RESIDUAL:** -history of at least one previous episode of Schizophrenia with prominent psychotic symptoms, (i.e., #27, #28, #26) -or admission to clinical care -continuing evidence of illness (i.e., #1, #40, #26, #16)
Appendix B—Continued

COURSE (5th digit)

1 Subchronic: signs of illness less than 2 years, at least 6 months

2 Chronic: symptoms more than 2 years

3 Subchronic with acute exacerbation: reemergence of psychotic symptoms in individual with subchronic course who has been in residual phase

4 Chronic with acute exacerbation: reemergence of psychotic symptoms in individual with chronic course who has been in residual phase

5 In remission: history of schizophrenia, free of all signs of illness (whether or not on medication)

B. 295.40 SCHIZOPHRENIFORM: Meets all criteria for schizophrenia, except duration of more than 2 weeks, less than 6 months.

C. 298.80 BRIEF, REACTIVE PSYCHOSIS: At least 1 psychotic symptom (i.e., #27, #28, #26, #52) apparently caused by a recognizable and legitimate psycho-social stressor. Symptoms last more than a few hours, but less than 2 weeks, with return to premorbid functioning.

D. 295.70 SCHIZOAFFECTIVE DISORDER: Unable to make differential diagnosis with any degree of certainty between Affective Disorder or Schizophreniform or Schizophrenia.

E. 298.90 ATYPICAL PSYCHOSIS: Psychotic symptoms (i.e., #26, #27, #28) that do not meet criteria for any specific mental disorder.

PARANOID DISORDER

PARANOID DISORDER: Predominant feature #28 with content of #4 or #5
-- duration of at least 1 week
-- NOT Schizophrenia or Affective or Organic
-- NO #27

297.10 PARANOIA: Same as above, at least 6 months duration
-- NOT Shared Paranoid (See below)
297.30 **SHARED PARANOID DISORDER:**
Meets Paranoid Disorder criteria
-- Delusions develop as a result of a close relationship with another person or persons who have persecutory delusions.

298.30 **ACUTE PARANOID DISORDER:**
Meets Paranoid Disorder criteria
-- **Less** than 6 months duration
-- **NOT** Shared Paranoid Disorder (see above)

297.90 **ATYPICAL PARANOID DISORDER:**
Meets Paranoid Disorder criteria, but none of the above specific disorders

**AFFECTIVE DISORDERS**

A. **MANIC EPISODE:** Predominant features #47 or #44
-- duration of symptoms for at least one week (or less if hospitalization is necessary) with at least 3 of the following: #60, #2, #62 (count as 2); #33, #50, #25.

5th Digit Code Number's

6 = In Remission - previous mania, now free from symptoms
4 = With psychotic features—#27, #28, #26 and #16 also predominant
2 = Without psychosis
0 = Unspecified

-- NO #27 or #28 or #16 as dominant symptoms, if so, Manic with psychotic features
-- NOT superimposed on Schizophrenia, Schizophreniform, Paranoid, or Organic Mental Disorders
-- NOTE: Mania generally begins suddenly, with a rapid escalation of symptoms over a few days.

B. **DEPRESSIVE EPISODE:** Predominantly symptoms #42 or #45
At least 4 of the following: 1) #48 2) #49 or 50 3) #48 or 60 4) #58 5) #42 6) #70 7) #25 8) #46

-- duration of above symptoms at least 2 weeks
-- no #27 or #28 as predominant symptoms, if so, depression with psychotic features
-- NOT superimposed on Schizophrenia, Schizophreniform, Paranoid OBS
Appendix B—Continued

5th Digit Code Number's

6 = In remission - previous depression, now free from symptoms

4 = With psychotic features (e.g., #27 or #28)

0 = Unspecified

3 = With melancholia - #42 with 3 of the following:
   1) distinct quality of depressed mood, i.e., depressed mood is perceived as different from kind experienced after death of loved one; 2) depression worse in morning; 3) early morning awakening at least 2 hours before usual time; 4) #60 or #48; 5) #58 (weight loss); 6) #70

C. BIPOLAR, MIXED: Both Manic and Depressive episodes, intermixed or rapidly alternated -- depression prominent and lasts at least 1 day -- use mania 5th digit codes.
   296.6x

D. BIPOLAR, MANIC: Most recently in a manic episode (does not have to meet full criteria for mania)
   296.4x

E. BIPOLAR, DEPRESSED: Has had one or more manic episodes, but currently in a major depressive episode (does not have to meet full criteria for depression)
   296.5x

F. MAJOR DEPRESSION, SINGLE EPISODE: Depressive episode, NEVER had a manic episode.
   296.2x

G. MAJOR DEPRESSION, RECURRENT: More than one depressive episode, NEVER a manic episode
   296.3x

H. CYCLOTHYMIC DISORDER: Both depression and mania, but neither severe enough to be exclusively either -- may be periods of normal mood that may last months.
   -- NO psychosis (#26, #27, #28) or other mental disorder.
   301.13

I. DYSTHYMIC DISORDER: Depression (#45, #42, etc.) over a 2 year period not severe enough to be considered major depression. May have periods of normal mood for days or weeks (not more than a few months).
   -- NO psychosis (#26, #27, #28).
   300.40
J. **ATYPICAL BIPOLAR:** Manic features, cannot be classified as bipolar or cyclothymic.
296.70

K. **ATYPICAL DEPRESSION:** Depressive symptoms cannot be classified as having major or other affective disorder.
296.82

**ANXIETY DISORDERS**

A. **PHOBIC DISORDERS** *(PHOBIC NEUROSIS)*
   1. 300.22 **AGORAPHOBIA:** #65, specifically avoids being alone or in places from which escape might be difficult or help not available in cases of sudden incapacitation, e.g., crowds, tunnels, bridges, etc.
      -- NOT due to any other disorder
   
   300.21 **AGORAPHOBIA WITH PANIC ATTACKS** (See below description of Panic Attacks)

   2. 300.23 **SOCIAL PHOBIA:** #65 and #1, person fears that he or she will act in a way that would be humiliating or embarrassing, e.g., performing or eating in public.
      -- NOT due to any other disorder

   3. 300.29 **SIMPLE PHOBIA:** #65, all other fears besides Social or Agoraphobia, e.g., animals, heights, closed spaces.

   4. 300.01 **PANIC DISORDERS:** 3 panic attacks within a 3 week period (except in a life threatening situation or physical exertion). Symptoms of 4 or more: sweating, faintness, trembling, chest pain, palpitation, dizziness, tingling in hands, hot or cold flashes, dyspnea, feelings of unreality.
      -- NOT due to another disorder.

C. 300.12 **GENERALIZED ANXIETY DISORDER:** At least 3 of the 4 categories listed in #66.
      -- NOT due to another mental disorder
      -- at least 18 years old

D. 300.30 **OBSESSIVE-COMPULSIVE DISORDER:** #67 or #68
      -- NOT due to another mental disorder

E. **POST TRAUMATIC STRESS DISORDER:** Predominant symptom #69
   Any 1 of the following: #1, #40, #42
   Any 2 of the following: #49 or 50, #20, #70,
   Hyperalertness or startle response, avoidance of activities that remind individual of trauma,
Appendix B—Continued

intensification of symptoms if around activities that remind individual of trauma.

COURSE: 1. 308.30 Acute: onset of symptoms within 6 months of trauma, duration less than 6 months
2. 309.81 Chronic: duration of more than 6 months
3. 309.81 Delayed: onset of symptoms 6 months after trauma

F. 300.00 ATYPICAL ANXIETY: Person has anxiety disorder that does not meet any specific criteria.

SOMATOFORM DISORDERS AND PSYCHOLOGICAL FACTORS AFFECTING PHYSICAL CONDITION

300.81 SOMATIZATION DISORDER: Predominant feature #53 -- history of physical symptoms of several years duration beginning before age 30

300.11 CONVERSION DISORDER: Predominant feature #56 -- NOT due to Somatization or Schizophrenia -- NOT just pain or sexual dysfunction -- judged to be NOT under voluntary control

307.80 PSYCHOGENIC PAIN DISORDER: #56 with pain as symptom -- Pain symptom is either inconsistent with anatomic distribution or cannot be accounted for by organic pathology after examination. -- NOT due to another mental disorder

300.70 HYPOCHONDRIASIS (HYPOCHONDRIACAL NEUROSIS): #55 which causes impairment in social or occupational functioning. -- NOT due to another mental disorder

300.70 ATYPICAL SOMATOFORM DISORDER: #56 or #53 without all 12-14 symptoms -- physical symptoms or complaints that do not meet any listed criteria for somatoform disorder (e.g., preoccupation with defect in physical appearance)

316.00 PSYCHOLOGICAL FACTORS AFFECTING PHYSICAL CONDITION: #54 (e.g., obesity, tension headache, migraine, angina pectoris, painful menstruation, arrhythmia, gastric ulcer, asthma, rheumatoid arthritis, neurodermatitis, colitis, nausea, etc.)

NOTE: List all appropriate physical conditions of AXIS III
DISSOCIATIVE DISORDERS

300.12 PSYCHOGENIC AMNESIA: Predominant feature #21.
 -- NOT due to Organic Mental Disorder

300.12 PSYCHOGENIC FUGUE: Predominant feature #21, with
sudden, unexpected travel away from one's home or
customary place of work--may assume new identity
 -- NOT due to Organic Mental Disorder

300.14 MULTIPLE PERSONALITY: Predominant feature #18, each
individual personality is complex and integrated with
its own unique behavior patterns and social
relationships.

300.60 DEPERSONALIZATION DISORDER: #35
 -- NOT due to any other mental disorder
 -- NOTE: Mild depersonalization normally occurs at
 some time in 30-70% of young adults.

PERSONALITY DISORDERS (AXIS II)

-- personality traits that are inflexible and maladaptive,
cause significant impairment in social or occupational
functioning or subjective distress

A. PARANOID: Predominant symptoms: #4, #5, and #6 or #10
  301.00 NOT due to a psychotic disorder

B. 301.20 SCHIZOID PERSONALITY: Predominant symptoms:
 #6 with #10, #1
 -- NOT due to psychosis

C. 301.22 SCHIZOTYPAL PERSONALITY: At least 4 of the
 following: 1) #30 2) #31 3) #12 4) #1 5) #61
 6) #10 or 6 7) #5 8) #4
 -- NOT Schizophrenia

D. 301.50 HISTRIONIC (HYSTERICAL): #11, 2 of the following:
 1) #11 2) #12 3) #15 4) #46 5) #6

E. 301.81 NARCISSISTIC: Predominant symptom: #12, cool
indifference or feelings of rage, inferiority, shame,
humiliation or emptiness in response to criticism,
indifference of others, or defeat
F. 301.70 **ANTISOCIAL**: Predominant symptom: #7
--- at least 18 years old
--- at least 4 antisocial manifestations, such as:
    inability to sustain current work, irresponsible
    parent aggressiveness, failure to honor financial
    obligations, repeated lying, etc.
--- pattern of continuous violation of rights of
    others since age 15 (except if in hospital or
    institution)

G. 301.85 **BORDERLINE**: Predominant symptom: #19

H. 301.82 **AVOIDANT**: Predominant symptom: #13

I. 301.60 **DEPENDENT**: Predominant symptom: #15

J. 301.40 **COMPULSIVE**: Predominant symptom: #14

K. 301.84 **PASSIVE-AGGRESSIVE**: Predominant symptom: #9

**ORGANIC**

A. Delirium: #25, #57 or 36, #20 (if testable); at least
   2 of the 4.
   Category:  
   1. #27, #28, or #30
   2. #64
   3. #49 or 50
   4. #48 or 51

   Delirium symptoms develop over a short period of time
   (hours to days) and tend to fluctuate over the course
   of the day.

293.00 Delirium (Axis I) due to pathophysiological
   process, e.g., pneumonia or brain tumor (Axis III).

291.00 Alcohol Withdrawal Delirium
   - Delirium occurs within one week as a result
     after cessation of or reduction in heavy
     alcohol ingestion.
   - autonomic hyperactivity, e.g., tachycardia,
     sweating, elevated blood pressure.

292.00 Barbiturate or Similarly Acting Sedative or
   Hypnotic Withdrawal Delirium
   - delirium occurring within one week after
     cessation of or reduction in heavy use of a
     barbiturate or similarly acting sedative.
   - autonomic hyperactivity
292.81 Amphetamine or Similarly Acting Sympathomimetic Delirium
- delirium within 24 hours as a result of use of amphetamine or similarly acting sympathomimetic

292.90 PCP or Similarly Acting Arylcylohexylamine Delirium
- delirium due to PCP

292.81 Other or Unspecified Substance Delirium

Dementia: #23, #57 or 36 (or presumed organic factor), #20 and/or 22; at least one of the following categories:

1. #24
2. #3
3. #17
- found primarily (not exclusively) in elderly

294.10 Dementia (Axis I) due to pathophysiological process, e.g., brain tumor or pneumonia (Axis III)

290.xx Primary Degenerative Dementia, i.e., due to Alzheimer's & Pick's disease
- age of onset generally after 65
- insidious onset with uniformly progressive deteriorating course
- exclusion of all other causes of dementia

Subtypes

Senile Onset (after 65)

290.30 with delirium
290.20 with delusions (#28)
290.21 with depression
290.00 uncomplicated

Presenile Onset (age 65 or below)

290.11 with delirium
290.12 with delusions
290.13 with depression
290.10 uncomplicated
292.82 other or unspecified dementia
Appendix B--Continued

290.4x Multi-infarct dementia
- stepwise deteriorating course (i.e., not uniformly progressive) with "patchy" distribution of deficits (i.e., affecting some functions, but not others) early in the course.
- focal neurological signs and symptoms (e.g., exaggeration of deep tendon reflexes, gait abnormality, etc.)
- evidence, from history, physical exam or lab tests of significant cerebrovascular disease that is judged to be etiologically related to the disturbance

291.2x Dementia associated with Alcoholism (severity)
- dementia following prolonged, heavy ingestion of alcohol
- Dementia persists at least three weeks after cessation of alcohol ingestion.

Severity Criteria

291.21 Mild (mild impairment in social and occupational functioning)
291.22 Moderate (moderate social impairment - inability to function occupationally)
291.23 Severe (deterioration of personality and inability to function independently)
291.20 Unspecified

Amnestic Syndrome: Predominant features: #20 and #22, #57 or #36, NO #25 or #23

294.00 With pathophysiological

291.10 Alcohol Amnestic Disorder
- amnestic syndrome due to prolonged heavy ingestion of alcohol

292.83 Barbituate or Similarly Acting Sedative or Hypnotic Amnestic Disorder
- amnestic syndrome due to prolonged, heavy use of a barbituate or similarly acting sedative or hypnotic

292.83 Other or Unspecified Substance Amnestic Disorder
Appendix B—Continued

**Organic Delusional Syndrome**: Predominant feature: #28, #27 or #36.

*NOT* prominent: #25, #23, #27.

293.81 With pathophysiological

292.11 Amphetamine or Similarly Acting

**Sympathomimetic Delusional Disorder**

delusions due to recent use of amphetamines or during a period of long term use of moderate or high doses.

Predominant feature: #4 or at least 3 of the following:

1. #12
2. #44
3. #66
4. #60

292.11 Hallucinogen Delusional Disorder due to recent hallucinogen use.

- development of Organic Delusional Syndrome that persists beyond 24 hours after cessation of hallucinogen use.

292.11 Cannabis Delusional Disorder

- due to recent use of cannabis

- an Organic Delusional Syndrome within two hours of cannabis use, but does not persist beyond six hours following cessation of use.

292.11 Other or Unspecified Substance Delusional Disorder

**Organic Hallucinosis**: Predominant feature: #27, #57 or #36;

*NOT* prominent: #25, #23, #28 (Affective Disorder).

293.82 With pathophysiological

291.30 Alcohol hallucinosis

- #27 with predominant auditory hallucinations developing (within 48 hours) after cessation of or reduction in heavy ingestion of alcohol in an individual with alcohol dependence

- #66 in response to hallucinatory threats

305.30 Hallucinogen hallucinosis perceptual changes, e.g., #27, #28, #30, #33, #35, due to recent injection of hallucinogen.

- Maladaptive behavioral effects, i.e., #4, #66, #3
Appendix B—Continued

292.12 Other or Unspecified Substance Hallucinosis

Organic Affective Syndrome - #57 or #36
At least 2 of the following:
Depression - #60, #2, #62, #33, #50, #25
Manic - #58, #49, #50, #60, #48, #70,
        #42, #15, #46

NOT predominant: #25, #23, #28, #27

293.83 Organic Affective Syndrome - pathophysiological

292.84 Hallucinogen Affective Disorder
- recent use of hallucinogen causing OAS that persists beyond 24 hours after cessation of hallucinogen use

Organic Personality Syndrome: #57 or #36
- marked change in behavior or personality involving at least one of the following:
  1. #43
  2. #3
  3. #42
  4. NO #25, #23, #27, #28

Intoxication: #36 which causes any maladaptive behavior such as #3 or #44

303.11 Alcohol Intoxication
- recent ingestion of alcohol that causes maladaptive behavior such as #3, #5, #44, etc.

- corresponding physiological significance such as slurred speech, unsteady gait, etc.

310.10 with pathophysiological

291.40 Alcohol Idiosyncratic Intoxication
- marked behavioral change, i.e., #5 that is due to the recent ingestion of an amount of alcohol insufficient to induce intoxication in most people

- The behavior is atypical of the person when not drinking.

292.84 Other or Unspecified Substance Personality Disorder
305.40 Barbituate or Similarly Acting Sedative or Hypnotic Intoxication

- recent use of barbituate causing maladaptive behavior such as #3, #44, #17.

- Neurological signs such as slurred speech, unsteady gait, etc.

305.50 Opioid Intoxication

- recent use of opioid causing maladaptive behavior such as #3, #44, #17

- pupillary constriction or dilation

- Psychological signs such as euphoria, psychomotor retardation.

- Neurological signs drowsiness, slurred speech, impairment in attention or memory.

305.60 Cocaine Intoxication

- recent use of cocaine causing maladaptive behavior such as #3, #44, #17

- at least two physical symptoms within one hour of using cocaine, such as tachycardia, perspiration or chills, elevated blood pressure.

305.70 Amphetamine or Similarly Acting Sympathomimetic Intoxication

- recent use of amphetamine causing maladaptive behavior such as #3, #44, #17

- within one hour of use, at least two physical symptoms such as tachycardia, elevated blood pressure, perspiration or chills.

305.90 PCP or Similarly Acting Arylcyclohexylamine Intoxication

- recent use causing maladaptive behaviors such as #3, #44, #17.
305.20 Cannabis Intoxication
- recent use of cannabis causing #4, #5, #44, #17
- tachycardia and other physical symptoms such as increased appetite, dry mouth

305.90 Caffeine Intoxication
- recent consumption of excessive caffeine, usually more than 250 mg.
- at least five physical symptoms such as restlessness, nervousness, diuresis, cardiac arrhythmia, psychomotor agitation

Withdrawal - #39

291.80 Alcohol Withdrawal
- cessation of or reduction in heavy prolonged ingestion of alcohol, followed within several hours by coarse tremor of hands, tongue, and eyelids and other prescriptive symptoms such as nausea, vomiting, anxiety, sweating, etc.

292.00 Barbituate Withdrawal
- prolonged, heavy use of barbituates
- at least three physical symptoms such as nausea, vomiting, malaise or weakness, anxiety, tachycardia.

292.00 Opioid Withdrawal
- prolonged, heavy use
- at least 4 symptoms such as lacimation, rhinorrhea, pupillary dilation, piloerection, diarrhea, fever.

292.00 Amphetamine Withdrawal

292.00 Tobacco Withdrawal

294.80 Atypical or Mixed Organic Behavioral Syndrome
#57 - does not meet any criteria listed.

292.90 Other or Unspecified Substance Atypical or Mixed Organic Mental Disorder
References


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