THE PSYCHIATRIC RATING SCALE FOR DIAGNOSTIC CLASSIFICATION
OF CHILDREN AND ADOLESCENTS: Interrater Reliability

Dissertation

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By

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This study was designed to assess the reliability of "The Psychiatric Rating Scale for Diagnostic Classification of Children and Adolescents" as an instrument for determining diagnoses congruent with DSM-III criteria. In Phase I graduate students from a University doctoral program in psychology independently rated case vignettes and completed the 64-item rating scale to arrive at Axis I or II diagnoses consistent with DSM-III classifications for Disorders Usually First Evident in Infancy, Childhood, or Adolescence. Subsequent correlations to determine individual scale reliability yielded significantly positive correlations.

Clinicians practicing in three diverse metropolitan mental health settings acted as raters in Phase II of the study. Paired raters jointly interviewed a total of 54 child or adolescent patients and independently completed the rating scale to arrive at Axis I or II diagnoses. These diagnoses were subsequently correlated with diagnoses previously obtained by traditional psychometric methods. Phase II inter-rater agreement was 92 percent for Axis I and II combined,
with a .96 correlation. Rating scale diagnoses when correlated with traditional psychometric diagnoses yielded an overall rate of agreement on Axis I of 95 percent for Rater 1 and 90 percent for Rater 2 and correlations of .96 and .95 respectively. Clinicians were asked to rate a case vignette having previously been given an erroneous diagnosis. This attempt to assess rater expectancy effects yielded an agreement rate of 100 percent for the correct diagnosis. These results supported both major hypotheses of the study at a minimum of the .001 level of significance. They also confirmed a priori belief concerning limited intrusion upon rating scale reliability from rater expectancies. As a reliable and objective method of eliciting, structuring, and evaluating patient information, the rating scale could aide in reducing interdisciplinary interview variability and time expenditures among clinicians while providing an appropriate foundation for entry into treatment.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>LIST OF TABLES</th>
<th>iv</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>THE PSYCHIATRIC RATING SCALE FOR DIAGNOSTIC CLASSIFICATION OF CHILDREN AND ADOLESCENTS: INTERRATER RELIABILITY</strong></td>
<td></td>
</tr>
<tr>
<td>Introduction</td>
<td>1</td>
</tr>
<tr>
<td>Method</td>
<td>26</td>
</tr>
</tbody>
</table>

## Phase I

<table>
<thead>
<tr>
<th>Subjects</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Instrument</td>
<td></td>
</tr>
<tr>
<td>Raters</td>
<td></td>
</tr>
<tr>
<td>Analysis of Data</td>
<td></td>
</tr>
</tbody>
</table>

## Phase II

<table>
<thead>
<tr>
<th>Subjects</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Instrument</td>
<td></td>
</tr>
<tr>
<td>Raters</td>
<td></td>
</tr>
<tr>
<td>Procedure</td>
<td></td>
</tr>
<tr>
<td>Analysis of Data</td>
<td></td>
</tr>
</tbody>
</table>

Results | 31 |

Discussion | 34 |

Appendix | 40 |

References | 82 |
## LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Individual Scale Reliability for Diagnostic Classification</td>
<td>32</td>
</tr>
<tr>
<td>2. Interrater Reliability and Percent of Agreement for Rating Scale Diagnostic Classification</td>
<td>33</td>
</tr>
<tr>
<td>3. Correlation and Percent Agreement Between Rating Scale and Traditional Psychometric Criteria</td>
<td>34</td>
</tr>
</tbody>
</table>
THE PSYCHIATRIC RATING SCALE FOR DIAGNOSTIC CLASSIFICATION
OF CHILDREN AND ADOLESCENTS: INTERRATER RELIABILITY

Data can be organized in many ways. Psychiatrists have used classification as a basic method to bring order to the understanding of mental illness. While diagnostic agreement about particular characteristics occurs at some generic level, clinicians have notoriously varied in their styles of observation, data collection, and processing (Beck, 1962; Clavelle & Turner, 1980; Frank, 1975). The diagnostic classification of psychopathology has been traced to the earliest recorded data of science, as has been noted in multiple reviews, e.g., Holzberg and Wittenborn, 1953; Kauffman, 1976; Mezzich, 1979; Woods, 1979; and Veith, 1957.

In view of the multiplicity and confusion among classification systems (Group for the Advancement of Psychiatry, 1974; Menninger, 1963), Menninger has offered a terminus by carrying forward the reductionistic trend toward simplicity in classification with the suggestion that there is only "one class of mental illness--namely, mental illness" (Menninger, 1963, p. 9). The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (3rd ed.) has been described as the benchmark of current diagnostic systems. It represents considerable advancement over earlier observation and labeling.
Psychiatric nosology was pursued in antiquity, predating the Hippocratic system by approximately 1,000 years. The earliest formal diagnostic system was used in India about 1,400 B.C. (Woods, 1979). As cited by Menninger (1963), this system contained seven major categories of psychological disturbances.

To the credit of Hippocratic physicians, they sought the origin of mental disease within the person or within his immediate environment (Veith, 1957). Hippocrates, in the fifth century B.C., suggested six categories of mental illness: Phrenitis, Mania, Epilepsy, Hysteria, Melancholia, and Scythian disease (transvestitism) (Woods, 1979). Celsus, the encyclopedist of ancient medicine, organized Hippocratic disease concepts into a system where mental difficulties were separately classified and subdivided into acute and chronic states (Veith, 1957).

One of the first texts on mental complications was written by Soranus in the second century A.D. As mentioned by Veith (1957), On Acute and On Chronic Diseases dealt extensively with diseases involving the mind. Listed as affictions of an acute nature were Phrenitis, Lethargy, and Hydrophobia. Among those diseases considered chronic were Headache, Melacholia, Nocturnal Emissions, and, interestingly, Homosexuality. Predating recent therapies treatment consisted of "relaxing remedies and manipulations" (Veith, 1957, p. 386).
A trend toward correlating disease and bodily structure occurred in the sixteenth century. An early exponent of this anatomical approach was Jean Fernel. Fernel, as Veith (1957) states, developed a typographic classification system which divided diseases into general and specific types. Specific types were further subdivided into parts above the diaphragm and external diseases. Fernel's typographic plan directed nosographic efforts until the middle of the seventeenth century. At that time Felix Platter introduced a new system whereby classification was based on symptomatology suggesting that detailed observation would reveal irreducible and constant units representing different diseases. Francois Boissier de Sauvages, an eighteenth century physician, also based his classification on symptoms which he saw as being different diseases. His nosology consequently contained "no less than 2,400 different diseases" (Veith, 1957, p. 388).

However, it was becoming evident that theoretical speculations would not suffice in the differentiation of symptom from disease. What was needed was close and continuous association with patients. Philippe Pinel, having spent years in systematic observation of patients brought together the intellectual and clinical skills necessary to formulate a workable psychiatric nosology (Veith, 1957). Pinel felt patients should be classified according to the nature of their particular disease. Thus, his classification system simplified conceptions of insanity into five forms:
Melancholia, Mania with delirium, Mania without delirium, Dementia, and Idiotism. Although Pinel's simple nosography was later altered by his followers, it was his "ability to observe and to glean from his observations the basic principles of mental disease," that marked his greatest contribution to psychiatric nosography (Veith, 1957, p. 389).

Like Pinel, Jean-Martin Charcot practiced at the Salpetriere. He observed that "different morbid states may coexist or succeed one another in the same individual or family according to a determined order and certain laws," and concluded that a common cause existed to serve as a link between afflictions (Veith, 1957, p. 390). It was this determination which began to mark the application of fundamental sciences in the search for a somatic basis for mental symptoms. The thinking of Charcot, Pinel, and others opened new vistas for diagnosis, cure, and prevention.

As recounted by Woods (1979), Lord and Flemming determined that 19 different systems of psychiatric classification had been developed between 1845 and 1932. Among the most influential and flexible was Emil Kraepelin's. A student of Wundt's, Kraepelin applied experimental psychology to the practice of medicine and investigation of psychopathology. Kraepelin attempted to integrate symptoms and patterns of onset, course, and outcome by use of minute observations (Million, 1969). According to Veith (1957), Kraepelin's observations convinced him that "the principle requisite in
the knowledge of mental disease was an accurate definition of the separate disease process and the search for disease entities" (p. 391).

Out of the task of observation and history taking emerged Kraepelin's 1883 Compendium. A small text which grew to "2,425 pages in its 9th edition in 1927" (Veith, 1957, p. 391). Although, as Veith suggests, Kraepelin's nosography "led to an overemphasis of classification with a relative neglect of therapy" (p. 391), it was important in that it differentiated psychiatry from neurology and brought mental disease back into the general realm of medicine.

Classification for Kraepelin was intricately related to etiology, treatment, and prognosis (Frank, 1975; Zigler & Phillips, 1961) and his system became the final confirmation of the Hippocratic postulate that "there is no single sacred disease but that all diseases are equally sacred or equally natural" (Veith, 1957, p. 391).

Statistical data on the mentally ill have been kept in the United States since the decennial census of 1840, though there were no attempts made to differentiate types of mental disorder until 1880 (DSM-II, 1952, p. xi). As Kramer (1958) indicates in his introduction, it was not until 1923 when a special census of patients in hospitals for mental disease was completed that extensive diagnostic statistics on the mentally ill in the United States were again published.
Clinicians in the period between World War I and World War II used a system of 24 categories of classification (Frank, 1975; Woods, 1979). Prior to 1952 conditions existed which exacerbated the unreliability of psychiatric classification. McDowell (1982) cited Spitzer, Endicott, and Robin's description of psychiatric diagnoses: "a clinician seeking guidance on the criteria for a given diagnosis was dependent on textbooks . . . articles . . . and case descriptions . . . and the author's own conception of the illness was explicated" (p. 5).

The first edition of the Standard Nomenclature of Diseases served as basis for data collection on the characteristics of the mentally ill admitted to hospitals in the United States until publication of the Diagnostic and Statistical Manual I (DSM-I) in 1952. The DSM-I contained definitions associated with seven major categories of almost 100 specific diagnoses. Nineteen sixty-eight saw the publication of DSM-II containing 100 specific diagnostic disorders grouped under ten categories.

Major differences existed between the 1952 and 1968 versions of the Diagnostic and Statistical Manual system of classification. These differences have been specified and discussed by many researchers and clinicians (Frank, 1975; Mezzich, 1979; Nathan, 1969; Rosenhan, 1975). In his review of the literature, Frank (1975) determined that differences involved modification of disorder names, elimination of the
term "reaction," increased categories in the 1968 version, definitional changes, and advocation of multiple diagnosis recording.

The drafters of DSM-II, acknowledging that DSM-I provided the United States for the first time with standardized names, codes, and guidelines for differential diagnoses, attempted to provide significant improvements while maintaining the same approach. Attending the substantial improvements in the DSM-II classification system was the matter of degree of reliability. The reliability debate caused the expenditure of considerable energy among concerned investigators, both those who claimed the contemporary system lacked reliability (Eysenck, 1952; Rotter, 1954; Scott, 1958) and those who defended it against criticism (Poulds, 1955; Schmidt & Ponda, 1956; Seeman, 1953).

Spitzer, Endicott, and Robins (1975) identified the following reasons for the continued lack of high reliability which characterized both DSM-I and DSM-II (a) the clinician must rely on his own concepts of the diagnostic categories, (b) no formal definitions are given for most categories, (c) there are no indications of which features distinguished which conditions, (d) few guidelines exist to help the clinician make joint diagnoses, (e) frequently classificatory principles are functions of tradition with little evidence of validity, and (f) no operational rules exist to help in the determination of whether diagnostic criteria have been met.
Zigler and Phillips (1961) conclude that "the present classificatory system, even as a purely descriptive device, is still open to a . . . degree of criticism" (p. 613). They further state that "one must conclude that so long as diagnosis is confined to broad diagnostic categories, it is reasonably reliable, but the reliability diminishes as one proceeds . . . to narrower, more specific ones" (p. 611).

Reliability as a prerequisite to diagnostic classification systems has become an accepted fact for most researchers and clinicians (Beck, Ward, Mendelson, Mock, Erbaugh, 1962; Foulds, 1955; Rosenhan, 1975; Smith, 1966; Spitzer & Fleiss, 1974; Zigler & Phillips, 1961). The reasons for poor reliability of psychiatric diagnosis have been innumerated often (Beitchman, Dielman, Landis, Benson, Kemp, 1978; Spitzer & Fleiss, 1974; Zigler & Phillips, 1961).

In their reanalysis of psychiatric diagnostic reliability Spitzer and Fleiss (1974) cite Zubin (1967) who noted three different ways that diagnostic reliability is referred to in the literature: "agreement between independent diagnosticians examining the same patients, stability in diagnosis over time, and similarity in diagnostic frequencies for comparable samples" (p. 341). They agree with Zubin that the most fundamental would be interjudge agreement. In their review of the major studies of diagnostic reliability, Spitzer and Fleiss conclude that the reliability of psychiatric diagnosis as practiced since the 1950's "is not good" (p. 345). The
reasons for the unreliability are apparently remaining unchanged. Specifically, those factors identified as being related to unreliability were clarity and specificity of diagnostic rules, training of the diagnosticians, and the amount of information available about the patient (Beitchman, et al., 1978).

The appointment of the Task Force on Nomenclature and Statistics by the American Psychiatric Association in 1974 began the development of the third edition of the Diagnostic and Statistical Manual. Members of the Task Force, concurring with regard to DSM-II being somewhat unreliable and having other limitations were concerned with the achievement of the following goals:

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, 1979, p. 203)

The stated purpose of the DSM-III is to "provide clear description of diagnostic categories" (p. 12) thus enabling users to diagnose, communicate, study, and treat mental disorders (DSM-III, 1979). With these stated provisions the drafters of DSM-III attempted to include information and ideas gleaned by early as well as contemporary investigators in psychiatric diagnosis, e.g., Beck, Ward, Mendelson, Mock, Erbaugh, 1962; Helzer, Robins, Taibleson, Woodruff, Reich, Wish, 1977; Holzberg & Wittenborn, 1953; Rosenhan, 1975; Smith, 1966. Field trials of DSM-III began in 1977 to test the adequacy of its major classifications.

The DSM-III guiding policy was one of inclusiveness and as Schacht and Nathan (1977) indicate was indicative of the overall goal of DSM-III "to develop a classification system that will reflect our current state of knowledge regarding mental disorders" (p. 1018).

In their appraisal of the DSM-III final draft, Schacht and Nathan (1977) suggest that for purposes of enhanced reliability the DSM-III categories are relatively uncomplex thus concurring with previous notions of Zigler and Phillips (1961). Described as a major innovation by its authors, the DSM-III diagnoses take a multiaxial form. This was an attempt
to improve the potential for planning treatment, and predicting outcome, as well as, in categorizing and classifying (Schacht & Nathan, 1977).

Mezzich (1979) discusses patterns and issues in multiaxial psychiatric diagnosis. He suggests that the rationale for altering tradition in classificatory schemes included the "desirability . . . for a more comprehensive formulation to do greater justice to the complexity of clinical conditions . . . promote higher interrater diagnostic agreement . . . and detect areas of consensus and divergence and perhaps new nosological patterns" (p. 125).

Systems of multiaxial diagnosis have existed since Essen-Moller and Wohlfahrt (1947) proposed a model for multiaxial psychiatric diagnosis by way of amending the official Swedish classification of mental disorders. Mezzich (1979) identifies Wing (London), Ottosson and Perris (Sweden), Helmchen (Germany), and Strauss (United States) as early developers of multiaxial classificatory systems. Child psychiatrists, according to Mezzich (1979), have long been contributors to the development of multiaxial diagnostic systems. With regard to raising reliability by use of multiaxial classifications Mezzich (1979) in his evaluation of these systems states that "reliability or replicability of a diagnostic system is a necessary, although not sufficient requirement for its validity or usefulness" (p. 132). Continuing his appraisal of multiaxial systems and review of studies
conducted to ascertain their reliability, Mezzich (1979) concludes that though several methodological problems existed throughout the studies, the multiaxial model promises to improve diagnostic reliability and validity.

Concluding their appraisal of the DSM-III final draft, Schacht and Nathan (1977) indicate that it accomplished the primary tasks of redefining major terms and conditions, developing new categories, and defining mental disorder while at the same time addressing the DSM-II problem of categorizing only from symptoms, reducing the difficulty of multiple diagnoses, and improving interrater reliability by specifying criteria to serve as guides for diagnosis. As Spitzer, Forman, and Nee (1979) state regarding DSM-III reliability:

The interrater reliability of DSM-III is, in general, higher than that previously achieved and may be due to changes in the classification itself . . . separation of Axis I from Axis II conditions . . . systematic description of various disorders . . . and inclusion of diagnostic criteria (p. 815).

Rating scales have been generally described as means by which one can describe in quantitative form the symptoms and signs upon which psychiatric diagnoses are predicated (Butler, Lawlis, Nicolette, 1983; McDowell, 1982; Wittenborn & Mettler, 1951). From ancient times to contemporary factor analyzed scales developed in collaboration with psychiatrists, rating scales have quantitatively recorded inferences or
observations about specific symptoms, traits, or characteristics under investigation (Handbook of Psychiatric Rating Scales, 1981; Wittenborn & Mettler, 1951).

Begun in the psychological laboratories of Europe as instruments to help quantify sensory and perceptual responses, rating scales define a continuum of dimension along which judgements are placed. The World War I era saw the rapid growth of rating scale use as well as other quantification methods, particularly in areas of decision-making and prediction in industry, education, and the military.

Use of rating scales specifically for psychiatric purposes progressed slowly, although early examples devised for local use, i.e., specific research usage, were apparent in the 1920's and 1930's. An example of such pioneering efforts was the Phipps Psychiatric Clinic Behavior Chart designed and used at Johns Hopkins around 1930. Before and after World War II rapidly growing concern about mental health and illness, and the introduction of psychotropic drugs, led to the development of rating scales for use in clinical as well as psychopharmacological research by Federal, State, and private interests (Handbook of Psychiatric Rating Scales, 1981). Examples of rating scale applications include prediction, identification, investigation of diagnostic process, assessment of treatment efficacy, establishment of data base for record keeping, and explorations of intercorrelations between biological and cultural influences on behavior.
Rating scales became increasingly used for psychiatric diagnosis and research in an effort to improve objectivity and reliability (Cooper, Copeland, Brown, Harris, Gourlay, 1977; Copeland, Kelleher, Gourlay, Smith, 1975). Efforts to standardize clinical interviews and psychiatric symptom rating in diverse environments and among different interviewers were evidenced by such instruments as the Present State Examination and In-Patient Multi-dimensional Psychiatric Scale (Cooper, et al., 1977; Copeland, et al., 1975).

As interest in rating scale use increased diversity appeared with regard to application, population, and setting. Areas of application for rating scales were innumerated, as previously mentioned, in the 1981 *Handbook of Psychiatric Rating Scales*. Investigators became increasingly polarized expressing diverse beliefs about the level of abstraction in scale construction. Many clinicians expressed the belief that the appropriate function of psychiatric rating scales was minimization of clinical judgement by provision of behavioral characteristics in discrete molecular form. Others (Overall, Hollister, & Pichot, 1967) expressed differing views and supported them by demonstrating reasonable levels of reliability and validity of abbreviated scales characterizing global manifestations of psychopathology.

Due to the multiplicity of symptoms found among psychiatric patients, and variety of variables potentially capable of influencing interrater reliability researchers
have attempted to identify objectives for development of rating scale devices (Overall & Hollister, & Pichot, 1967). These efforts began in a series of studies conducted by Wittenborn (1951). Attempting to devise reliable and valid psychiatric diagnostic rating instruments, Wittenborn concluded that the following tenets and precautions must be stressed.

1. Rating scales must sample adequately the important symptoms in mental patients.

2. Rating scales must be restricted to currently discernible behavior so that their repeated use can reveal patient changes.

3. The scales must provide ratings which are relatively independent of the insights and sophistication of the rater.

4. The scale must provide ratings which are relatively independent of a bias or theoretical persuasion of the rater.

5. The scales must be of such form that each scale can be checked for every patient.

6. The scale must be feasible in so far as it draws upon behavioral features which are likely to be known or may be readily ascertained.

7. The scale must be simple in form and economical and convenient to use.

8. The 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)
Classification in adult psychiatry has been influenced by many investigators, most notably Kraepelin. As seen these various nosologies originate with man's earliest concerns about mental anomalies. Classifications are proven to be provisional and subject to constant revision, such seems the nature of taxonomists. Multiple efforts to assess the efficacy of these classifications as they pertain to psychiatric diagnosis have been carried out with varied results. And as Freeman (1971) points out, "any comparison of reliability studies must be qualified by knowledge of the setting, type of patient, and nomenclature of the study" (p. 43).

Classification of psychiatric disorders of childhood and adolescence has been "part and parcel" of adult classificatory systems. As Chess (1971) points out, the two major efforts in the United States at the classification of psychiatric disorders in childhood and adolescence are . . . DSM-I and DSM-II, attempts to coordinate American terminology with that of the World Health Organization's International Classification of Disease, and . . . the second . . . is the report **Psychopathological Disorders in Childhood: Theoretical Considerations and a Proposed Classification**, issued in 1966 by the Group for the Advancement of Psychiatry (GAP) (p. 785).

Historical nosologies as reviewed in the GAP formulations included workers having offered formal systems attempting to
deal with the total realm of psychopathology in childhood and adolescence. Lowrey (1931) and Strecker and Erbaugh (1931) published early schemes of classification. The Lowrey system identifies five groups of childhood psychological problems. Group I represents Gross Mental Deviations, Group II Gross Physical Deviations, Group III The Neuroses, Group IV Complexes and Conflicts, and Group V Problems of Ignorance or Faulty Training (Gap, 1974). The Strecker and Erbaugh system by comparison lists four types of psychological problems seen in children: (a) Reactive, (b) Toxic, Physical, and Organic, (c) Mental Deficiency, and (d) Psychoses (Gap, 1974). Many other researchers and clinicians have promulgated classifications for childhood and adolescence in the last fifty years (Ackerman, 1953; Beller, 1962; Chess, 1971; Jensen, 1959; Pacella, 1948; Ross, 1964; Settlage, 1964).

The DSM-II modeled on the ICD was most germane to the Chess (1971) discussion on nosology in child psychiatry. Chess asked the question, "how do you standardize terminology when there is disagreement over whether the diagnostic categories should be based on etiology or presenting symptoms or prognosis or a combination of these?" (p. 785). She further indicated that among a group of psychiatrists asked to respond to questions about the DSM-II, major complaints about the classification were as follows.

1. Developmental problems of children do not have a clear place.
2. Childhood personality or characterological deviations are hard to designate, since the terminology was designed for adult patients.

3. Categories of childhood psychosis and childhood schizophrenia as presented are difficult to use for child patients.

4. Behavior disorders and special symptoms are listed in terms of phenomenology and should not be given the status of a diagnostic category.

5. There is no diagnostic category for the healthy child.

6. No opportunity is provided to designate a reactive behavior disorder that is more than transient. (p. 786)

Following these responses Chess tested the Rutter, Lebovici, Eisenberg, Sneznevskij, Sadoun, Brooke, Lin, (1969) proposed tri-axial classification of mental disorders in childhood. It was concluded by Chess that "the basic responsibilities of a nosological system were met by the tri-axial scheme" (p. 787).

The efforts of diagnosticians to development of nosologies (GAP, 1974; Rutter, et al., 1969), interviews and mental status examinations (Cohen, 1976; Critchley, 1979; Kauffman, 1976; Werkman, 1965), and reliability and validity (Freeman, 1971; Rutter & Graham, 1968) in psychiatric assessment of children and adolescents has culminated in the current version of the American Psychiatric Association's system of
classification, DSM-III. This system incorporates in a
generic sense the definition of childhood psychiatric dis-
order proposed by Rutter and Graham (1968):

Psychiatric disorder . . . refers to abnormalities of
emotions, behavior, or relationships which are develop-
mentally inappropriate and of sufficient duration and
severity to cause persistent suffering or handicap to
the child and or distress or disturbance of the family
or community (p. 563).

Further, the DSM-III recognizes that the "fluidity of the
developmental dimensions of childhood does not lend itself to
static categorization" (Freeman, 1971, p. 43). In this
regard, Romano's statement cited in Menninger (1963) accur-
ately preceded the DSM-III drafter's philosophy:

Health and disease are not static entities but are
phases of life, dependent at any time on the balance
maintained by devices, genetically and experimentally
determined, intent on fulfilling needs and adapting to
and mastering stresses as they may arise from within the
organism or from without (p. 41).

A central problem in the investigation and treatment of
emotional disorders in children has been the lack of reliable
Chess (1971) mentions that among the 41 respondents to her
questionnaire, the consensus was that the widely used altern-
ative to DSM-II was that of the Group for the Advancement of
Psychiatry (GAP); especially in teaching. The respondents further reiterated the growing belief that a "classification initially designed for adults and then modified for children obscures the essential aspects of child development" (p. 787) thereby making it difficult to achieve comparability as it related to studies of prevalence or treatment efficacy.

A study of the reliability of psychiatric diagnosis in children and adolescents was undertaken by Freeman (1971) using the GAP classification. Participant psychiatrists (N = 20) from New South Wales demonstrated a high interindividual and intraindividual consistency equal to agreement studies in adult psychiatry. In an earlier study, Rutter and Graham (1968) found that reasonably sensitive diagnostic instruments could give rise to reliable and valid judgements about childhood psychiatric disorders.

Another means for overcoming the difficulties of reliability in childhood and adolescent psychiatric assessment has been the use of rating scales. The last twenty years has witnessed an awakening among clinicians and researchers to the usefulness of this approach. For example, Adlerton and Hoddinott (1968) discuss the development of the Children's Pathology Index (CPI) and subsequent efforts to determine its reliability and validity. The CPI consists of categories describing types of functioning, behavior, attitude, and relationship or emotional response. Each category contains ordered descriptive statements. The raters select the
statement that most typically describes the child. The CPI requires 20 to 30 minutes to administer and little staff training is required. Results of the CPI study demonstrated satisfactory reliability of the four factorially identified factors. A follow-up study by Alderton (1970) in an effort to determine the CPI's predictive capabilities found it to be adequate in the prediction of recidivism among boys hospitalized for acting-out behavior disorders.

A rating scale designed specifically for use with child psychiatry patients and proven useful in both clinical and research work was discussed by Wimberger and Gregory (1968). The Washington Symptom Checklist (WSCL) consists mainly of listed behavior items reported by parents to be symptoms of childhood psychiatric disorders. The WSCL can be completed by anyone knowing the child well in approximately 20 minutes. The use of symptoms for rating behavior has been discussed by Glidewell, Mensh, and Gildea (1957). Other studies reviewed by Wimberger and Gregory (1968) indicate that clinicians generally agree that clinical improvement correlates highly with symptom loss and further that the number and degree of symptoms correlate positively with existence of emotional disturbance. Problems that interfere with childhood and adolescent rating scale development include (a) the child is generally unable to rate himself, (b) ratings depend on the observations of others, and (c) the validity of parental judgements has often been at issue. However, in the case of
the WSCL, reliability by test-retest correlational analysis and individual item analysis was very high. Further, when comparing data provided by parents and therapists as a means of estimating validity, high agreement was also found.

The Global Assessment Scale (GAS) of Endicott, Spitzer, Fleiss, and Cohen (1976) evaluates in a single rating scale the overall functioning of a person for a particular time on a continuum from psychiatric sickness to health. The Scale values range from 1, hypothetically the most unhealthy person, to 100, the healthiest. Defining characteristics at each ten point interval comprise the scale. Studies by Endicott, et al. (1976) conclude the GAS achieved good inter-rater reliability. Indirect assessment of validity using correlations with other independently rated measures of overall severity, relationship to hospitalization, and sensitivity to change suggest reasonable associations among these factors.

Beitchman and Raman (1979) suggest that "two related but separate problems stand out as impediments to the advancement of child psychiatry as a science: (1) the absence of a reliable taxonomy, and (2) the absence of standardized and easily applicable quantitative methods" (p. 23). They further state that "no abundance (of rating scales) greets the researcher of child psychopathology" (p. 23) unlike the situation in adult psychopathology.
Two general approaches to data collection are extent in child psychiatry, self-report inventories and other-report inventories completed in most cases by teacher or parent. Important limitations exist for these instruments including reliance on observational data only, rater bias, and requirement of sufficient knowledge of the child or adolescent. The self-report Psychiatric Rating Scale for Children, adapted from existing inventories and newly devised items achieved test-retest correlations of discriminant scores of .70 for boys and .63 for girls. Support for discriminant validity was also found.

In a more contemporary vein, Hodges, McKnew, Cytryn, Stern, and Kline (1982) described data relevant to reliability and validity of the Child Assessment Schedule (CAS). The CAS was designed for clinical assessment of children as well as research data collection. Interrater reliability for the total CAS score was found to be .91 in one study and .90 in another. Concurrent validity data was determined to be encouraging.

The Brief Psychiatric Rating Scale for Children (BPRS-C), Overall and Pfefferbaum (1982) was developed to "provide a parsimonious description of childhood emotional and behavioral disorders" (p. 10). Factor analysis provided the basis for BPRS-C development. The original data were taken from descriptions of hypothetical typical patients among 18 diagnostic groups recorded on Guy's (1976) Children's Psychiatric
Rating Scale (CPRS). The BPRS-C was designed to characterize each patient and evaluate response to treatment in terms meaningful to various diagnostic classifications. Overall and Pfefferbaum (1982) consider the multidimensionality of the BPRS-C appropriate for describing major child and adolescent patient differences, characterizing them according to syndrome groupings, and for evaluation of treatment longitudinally. Currently available rating scales for clinical use from as early as 1962 have been described in the Handbook of Psychiatric Rating Scales (1981).

Relative to identification of symptom configurations as generally critical to psychiatric classification, Holzberg and Wittenborn (1953) emphasized the need for identifying behavioral criteria based on specific, quantified symptoms and facts rather than determination by speculation. Holzberg and Wittenborn (1953) cited as considerations supportive of the quantified rating scale procedure for obtaining diagnoses 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;
3. Achievement of 'less overlapping' of symptoms by empirically determining and weighting the symptoms which belonged together in clinically demarcated entities (p. 146).
They cautioned, however, that rating scale processes were not substitutes for traditional personality studies of patients but were designed to augment the usual descriptive diagnosis.

Diagnosis in spite of the various complexities and changes in classification systems has thus continued to function as a succinct means by which communications can be made about patients. The DSM-III represented an effort pointed at improved adequacy and systematic control of these inherently complex factors in diagnosis. However, the continued unreliability of psychiatric diagnoses may lie in the "variability of the operations by which clinicians have evaluated and used observations from interview data" (McDowell, 1982, p. 18).

The purpose of the present study was to establish The Psychiatric Rating Scale for Diagnostic Classification of Children and Adolescents as a reliable, structured, and convenient method of diagnosis and classification of children and adolescents. The Scale was developed according to DSM-III criteria and nomenclature as a means of increasing precision and reliability of multiaxial diagnosis.

This study was undertaken in two phases. The first phase determined the interrater reliability for revealing the presence of any of 10 clinical syndromes identified as Disorders Usually First Evident in Infancy, Childhood, or Adolescence by DSM-III. Through the use of this instrument it was hypothesized that a clinician could rate problematic behaviors, symptoms, or characteristics of children or
adolescents and use these ratings to determine a more reliable classification congruent with a DSM-III diagnosis than that usually achieved by clinical interview or psychometric assessment. The second phase of the study established the Scale as a reliable means of diagnosis, congruent with DSM-III, in the reality of actual clinical practice.

Method

Subjects

Eleven case vignettes were used in Phase I of the study. Each vignette represented one of the 10 major clinical syndromes assessed by this instrument. The eleventh vignette served as a "control" representative of a "no pathology" condition (see Appendix A). The case vignettes were obtained from the DSM-III Case Book, Spitzer, Skodol, Gibbon, Williams (1981), and the DSM-III Training Guide, Webb, DiClemente, Johnstone, Sanders, Perley (1981). The validity of the "control" case used in this study was ascertained by review of experts in DSM-III classification and psychiatric diagnosis of children and adolescents.

Instrument

The Psychiatric Rating Scale for Diagnostic Classification of Children and Adolescents was based wholly on the descriptive categories and diagnostic criteria listed in DSM-III (see Appendix C). The Scale comprizes 64 specific problem behaviors, symptoms, or characteristics briefly
listed and described. These significant criteria are organized under convenient identifying categories of Social and Interpersonal Relationships, Intellectual and Academic Functioning, Physical or Perceptual-motor Involvement, Developmental Concerns, Language and Speech, Affective Behavior, and Anxiety and/or Fears. At the right of the symptom descriptors are 10 columns (A-J) which correspond to the 10 separate major clinical syndromes: Mental Retardation, Attention Deficit Disorder, Conduct Disorder, Anxiety Disorders of Childhood or Adolescence, Other Disorders of Infancy, Childhood, or Adolescence, Eating Disorders, Stereotyped Movement Disorders, Other Disorders with Physical Manifestations, Pervasive Developmental Disorders, and Specific Developmental Disorders (Axis II).

Raters received written instructions (see Appendix B). The rater, to use the Scale, determined relevant problematic symptoms, behaviors, or characteristics of each subject case and placed a check mark in the appropriate column beside each item. The check marks were weighted when applicable and totaled for each column. From the results of these totals, the rater identified the subject case as displaying "Some" or "Substantial" evidence of one or more of the clinical syndromes (see Appendix D). With this data the rater ascertained the specific disorder and DSM-III code number by use of the Coding Guidelines (see Appendix E). Information for multiaxial determinations on each subject case was supplied (see Appendix D).
Raters

Graduate students (N = 10) from the psychology program at North Texas State University served as raters for this phase of the study. Male and female raters of varying age and background were used. Each rater had completed a graduate level psychopathology class and various amounts of hours. Five randomly chosen students rated 5 of the 11 case vignettes using the Scale. The remaining 5 students served as raters for the other 5 cases. All students rated the "control" case. A total of 6 cases was rated by each rater.

Analysis of Data

The Pearson Product Moment Correlation Coefficient and Chi-Square test were used to analyze the data. A correlation coefficient was determined for each individual column (A-J) separately for the 10 raters and 11 cases to assess individual scale reliability. The chi-square test was subsequently used to determine the relationship between the two groups of student raters.

Subjects

Subjects for Phase II of the study were randomly selected from child and adolescent patients seeking care at a metropolitan Mental Health and Mental Retardation Center, a Child Guidance Center, or a Health Maintenance Organization (HMO). The only restrictive criteria for inclusion in the study was age (less than 18 years old) and appropriateness for DSM-III categories for the Disorders Usually First Evident in Infancy, Childhood, or Adolescence.
Instrument

The Psychiatric Rating Scale for Diagnostic Classification of Children and Adolescents as previously described was also used in this phase. The Scale focuses on descriptions of observed behavior which accurately characterize the patient. The Scale is not designed for etiologic, prognostic, or dynamic considerations. The Scale provided a quantified means by which patients could be described and the degree ascertained to which their observable behaviors concur with DSM-III classifications.

Raters were required to obtain signed Informed Consent forms (see Appendix F) and then to compare each patient with the 64-items on the Scale. After comparison raters recorded their decisions as to the presence or absence of each symptom descriptor. Compilation of check marks was completed in the aforementioned manner and weightings determined which identified the patient as having "Some" or "Substantial" evidence of a specific syndrome.

Raters

Clinicians prepared at both doctoral and masters levels in psychology and social work served as raters. Diagnosticians were currently practicing in either the Child/Adolescent Unit of a metropolitan MH/MR, a Child Guidance Clinic, or a Health Maintenance Organization (HMO). Male and female raters varied as to age, background, and theoretical orientation. None of the raters had prior experience with the Scale.
The range of rater background with DSM-III child and adolescent diagnosis was from knowledgeable and experienced to a more limited familiarity.

Procedure

The raters participated in two-hour training sessions designed to minimize individual differences in interviewing techniques as they relate to observation, classification, and diagnosis. During the training raters reviewed the Scale and its diagnostic guidelines, discussed the criteria of the diagnostic categories, and practiced rating sample cases. A training procedure of this type was used to insure all raters shared a similar familiarity with, and understanding of the Scale items. Raters were instructed not to discuss their ratings or diagnoses with other raters during the course of the study.

Each patient was seen by two randomly paired diagnosticians. The interviewing process was arranged such that each interviewer/observer pair saw approximately the same number of patients, used the Scale approximately the same number of times, and acted as both interviewer/examiner and observer/rater on approximately equal numbers of occasions. One rater interviewed the patient while the other rater silently observed. Each rater completed the rating scale independently following the clinical interview and made his/her conclusion regarding diagnosis. Both raters using the research instrument made judgements about the presence, absence, and severity of symptoms from the interview content and devised separate multiaxial diagnoses (see Appendix G).
It was hypothesized that there would be a significant positive correlation between diagnostic classifications derived by the independent raters using the Scale. It was further hypothesized that there would be a significant positive correlation between diagnostic classifications resulting from use of the Scale and diagnostic classification derived by other standard psychometric criteria. Additionally, it was hypothesized that use of the Scale would reduce bias as related to rater expectancy effects. The attempt to ascertain Scale susceptibility to rater expectancies was made during the training period. All diagnosticians rated a case vignette after having been deliberately misinformed as to the diagnostic classification. Rater diagnoses were later analysed to determine the degree of expectancy introduced by the misinformation.

Analysis of Data

Interrater reliability for the diagnostic classes represented by the patient sample, as well as, the overall agreement between rating scale diagnoses and traditional psychometric diagnoses was determined by computation of Phi-coefficients of correlation and percentages of agreement.

Results

Phase I data were analysed using the Pearson Product Moment Correlation Coefficient. The check marks placed in each column (A-J) were correlated to determine individual scale reliability by case (see Table 1).
### Table 1

**Individual Scale Reliability for Diagnostic Classification**

<table>
<thead>
<tr>
<th>Scale</th>
<th>$r$</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Mental Retardation</td>
<td>.96*</td>
</tr>
<tr>
<td>B Attention Deficit Disorder</td>
<td>.89*</td>
</tr>
<tr>
<td>C Conduct Disorder</td>
<td>.92*</td>
</tr>
<tr>
<td>D Anxiety Disorders of Childhood or Adolescence</td>
<td>.93*</td>
</tr>
<tr>
<td>E Other Disorders of Infancy, Childhood, or Adolescence</td>
<td>.59</td>
</tr>
<tr>
<td>F Eating Disorders</td>
<td>.83**</td>
</tr>
<tr>
<td>G Sterotyped Movement Disorders</td>
<td>.86**</td>
</tr>
<tr>
<td>H Other Disorders with Physical Manifestations</td>
<td>.79**</td>
</tr>
<tr>
<td>I Pervasive Developmental Disorders</td>
<td>.43</td>
</tr>
<tr>
<td>J Specific Developmental Disorders</td>
<td>.77**</td>
</tr>
</tbody>
</table>

*N = 10.*  
* $p < .001$.  **$p < .01$.  

Reliability for Scales A through D was significant at the $p < .001$ level. Scales F, G, H, and J were significant at the $p < .01$ level. Approaching significance at the $p < .05$ level were Scales E, and I. Control case diagnosis was uniformly "Normal" across raters therefore no determination of correlation was necessary. Interrater diagnostic agreement across cases was determined using Chi Square. Rater agreement was found to be highly significant, $(X^2 = 435, df = 1, p < .001)$. 
Phase II data for determination of reliability among diagnostic classes, as well as the agreement between rating scale diagnoses and traditional psychometric diagnoses, were examined by computation of Phi-coefficients of correlation and percentages of agreement. Patients participating in the study ranged in age from 2 - 17 years, 34 were male and 20 were female. The socioeconomic status of patient families varied from poverty to affluence, and the ethnic-racial distribution consisted of white, not of hispanic origin (72%), black, not of hispanic origin (13%), hispanic (4%), and other (11%).

Agreement between diagnosticians using the "Psychiatric Rating Scale for Diagnostic Classification of Children and Adolescents" (see Table 2) yielded a correlation of .96 for Axis I and II combined which was significant at the $p < .001$ level. Interrater agreement of 92 percent was reached at this stage.

Table 2

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>r</th>
<th>Percent Agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Axis I &amp; II</td>
<td>.96*</td>
<td>92%</td>
</tr>
</tbody>
</table>

*$p < .001.$
A comparison of diagnoses derived from traditional psychometric methods and those determined from use of the rating scale by independent rater pairs (see Table 3), revealed correlations of .96 (95%) and .95 (90%) for Axis I. The results given in Table 3 are significant at the $p < .001$ level, indicative of an overall diagnostic agreement rate of 93 percent across Axis I and Axis II. Axis II, Specific Developmental Disorders, agreement across raters and between rating scale and traditional psychometric diagnoses ($N = 6$) was uniformly without variance, i.e., 100 percent. Results of diagnostician ratings of the case vignette on which they were misinformed as to the correct diagnosis revealed that through use of the rating scale 100 percent of clinicians were able to derive a correct diagnostic classification.

Table 3

Correlation and Percent Agreement Between Rating Scale and Traditional Psychometric Criteria

<table>
<thead>
<tr>
<th>DSM-III Axis</th>
<th>Rater 1 $r$</th>
<th>Rater 1 %</th>
<th>Rater 2 $r$</th>
<th>Rater 2 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>.96*</td>
<td>.95%</td>
<td>.95*</td>
<td>.90%</td>
</tr>
</tbody>
</table>

* $p < .001$.

Discussion

The data of the Phase I investigation strongly supported the hypothesis that use of the "Psychiatric Rating Scale for
Diagnostic Classification of Children and Adolescents" would result in an interrater reliability leading subsequently to higher diagnostic agreement between raters and with DSM-III classification.

It can be presumed in light of the significance of Phase I results that the diagnosis and classification of disorders of childhood and adolescence will become increasingly uniform among diagnosticians. A classification system with high reliability serves to enhance the accuracy of diagnosis. During Phase I the rating scale performed in this capacity by providing raters the means to systematically analyze relevant information and reduce variability and bias associated with their heterogeneous theoretic orientation, experience, and sophistication.

The most significant correlation found in the DSM-III field trials conducted by Spitzer et al. (1979) was .78 for joint interviews on Axis I. For diagnoses made in separate interviews this interrater correlation dropped to .66. By comparison the scale reliabilities obtained in Phase I suggest that a structured, objective, and more standardized format can further increase interrater reliability. It also appears likely that the diagnostic process can be further enhanced by following the rating scale procedural guidelines which more succinctly define the behaviors and characteristics related to specific diagnostic classifications.
The case vignettes from the DSM-III casebook and training guide provided Phase I raters with identical case material and were considered preferable to real subjects in obtaining an initial measure of interrater reliability. However, using case vignettes may have injected a disadvantage in that raters were unable to make in vivo observations or to inquire further regarding "hypotheses" about behaviors or symptoms. It would seem reasonable then that use of actual patients may increase the accuracy of clinician ratings. Phase II of the study addressed this issue.

The reliabilities for Scale E (r = .59) and Scale I (r = .43) approached significance at the p < .05 level. The reasons for these lower reliabilities are not entirely clear. However, several explanations seem pertinent. It may have been that for the two classes of disorder in question a statistical artifact resulted from limited options, i.e., behaviors, characteristics, or symptoms, in columns E and I, resulting in numbers insufficient for adequate statistical treatment. Another possibility may be found by examining Table 1 which reveals an apparent linearity of correlational significance of such that as classification ambiguity increases the significance of correlation decreases. The very problem of overlap which has plagued psychiatric nosology from its inception. This lack of clarity and precision in classification would also be evident in the case vignettes thereby reducing the opportunity for significant reliability among
raters. A final consideration concerns the relative lack of sophistication of raters chosen for Phase I. The lack of familiarity and experience found among graduate students in training should be overcome by use of experienced clinicians.

The rating scale as assessed in Phase I appears to increase interrater reliability in psychiatric diagnosis. It has further advantage of ease of scoring and could save professional time and effort by allowing for scoring by trained technicians.

Phase II of the study projected the investigation into the reliability of the "Psychiatric Rating Scale for Diagnostic Classification of Children and Adolescents" into the real world. Using children and adolescents (N = 54) seeking treatment at either a metropolitan MH/MR Center, Child Guidance Center, or Health Maintenance Organization (HMO). Patients signed informed consent releases and were then interviewed by paired raters of varied educational and theoretical experience. Independent diagnoses were derived by each rater according to DSM-III criteria. Significant positive correlations between diagnostic classifications arrived at by raters, as well as between rating scale diagnoses and traditional psychometric diagnoses, supported both major hypotheses of the study. A secondary hypothesis was also supported as participant raters correctly diagnosed a case vignette after being incorrectly informed as to its diagnostic classification during training. In effect this
finding successfully precludes concerns for the instrument as to rater expectancy influences.

Although this study did not directly address the question of whether the clinical diagnosis was valid or invalid, statistical analysis of results suggests that the instrument is adequate for evaluation of differences among diagnostic types and in providing DSM-III consonant diagnoses. It was further demonstrated that diagnoses based upon the objective rating from the scale correlated significantly and positively with traditional psychometric diagnoses. If the indices of agreement were used to estimate scale validity, they would show that the validity of the rating system approached its reliability.

Other rating scales and structured interviews have been promulgated, i.e., Overall et al. (1967); Wittenborn (1951). However, they are not based on the DSM-III system. The implications for use of the "Psychiatric Rating Scale for Diagnostic Classification of Children and Adolescents" system for diagnosis, therefore, appear to be multiple and varied. Its specificity of item content and guidelines for definition of rated behaviors clearly make it feasible for use by trained allied health professionals familiar with child and adolescent populations. The unique structure of the scale lends itself to multidisciplinary diagnostic training and to use by experienced mental health professionals who are without extensive familiarity with DSM-III nomenclature and criteria.
Another advantage of using the scale appears to be that it precludes by breadth of item description provided by the guidelines the tendency of clinicians to make too rapid diagnoses when presented with specific salient symptom or behavior patterns which in fact may be representative of an entirely different diagnosis. By use of the scale during diagnosis a process of systematic exclusion occurs which leads to DSM-III congruent classifications. Additionally, in opposition to the DSM-III field trials (Spitzer, Forman, Nee, 1979) and studies reported by Beck et al. (1962), the present results reveal consistent agreement between raters on both Axis I and Axis II.

In looking toward the future, research should be undertaken to help refine the specificity of scale items toward clarity of description in disorders such as Pervasive Developmental Disorders. Studies which more rigidly test interrater reliability in terms of agreement between raters on each of the 64 symptom categories for each client could provide an indication of whether specific items consistently account for frequent or marked rater disagreement. Clinicians could also be requested to record those behaviors, characteristics, or symptoms considered most ambiguous or difficult to code, thereby indicating areas of possible improvement in the scale or its guidelines.
Appendix A

Case Vignette

Roger is nine years old. In his three years of school Roger has experienced increasing difficulty keeping up. His language development has lagged behind his peers and although he makes friends easily his clumsiness keeps him from being included in team sports.

Roger's parents separated when he was one year old. He has had little contact with his father since then. Roger is the youngest of four children.

Roger's mother described her pregnancy as "stormy." Her delivery was lengthy and Roger was kept in an incubator with oxygen for several days because he was "real blue." She was 44 years old when Roger was born.

Roger developed slowly, walked and talked late, and not easily toileted. He was generally happy but frustrated easily, threw tantrums, and was often irritable. Socially, Roger remains significantly behind his peers.

Roger's teacher suggested that he be tested for possible special education placement and his mother agreed. Results indicate that Roger is below average in independent functioning, has poor social skills, and an Intelligent Quotient of 70.
Appendix A—Continued

Case Vignette

The school referred Jim, six years of age, because "he requires constant supervision to keep him from disrupting classroom activities." He is also described as "stubborn, defiant, and quarrelsome," and as having a very short attention. Every school he has attended has had the same complaints about his behavior; he is overactive, uncontrollable, disruptive, and impulsive.

His mother states that at home Jim never keeps still for any length of time; he is always running, jumping, rocking, or fiddling with something. She describes him as doing three or four things at a time without completing anything. He has very poor judgement and goes off anywhere by himself and does whatever he wants to do. He is extremely intrusive and disrupts any activity in which others are attempting to engage. His mother feels that he demands her undivided attention. Furthermore, she says, he is always provoking his older brother, and has a "wild" temper, which erupts very dramatically and suddenly and disappears in the same fashion.

As an infant Jim was constantly climbing out of his crib and highchair, and couldn't be contained. As a toddler he was into everything, and his parents made many visits to the emergency room because of his minor accidents. He climbed alot, jumped all over the furniture, and refused to stay in his playpen.
During the evaluation Jim spent most of the time walking around the office or tilting a chair, leaning on its back, and rocking back and forth. He jumped from subject to subject and talked incessantly. He acknowledged having some difficulty in school, but felt it was strictly because the other children picked on him.
Case Vignette

The school counselor was asked to see this 13-year-old boy for persistent truancy and smoking on school property. He was a rather popular fellow and many peers thought of him as a "real friend." The counselor contacted his parents and found that at home, too, there were difficulties, in that he was frequently caught in lies and stealing money from his mother's purse.
Case Vignette

Michael, seven and a half years old, is brought in by his mother, who had read an article in a local newspaper about a clinic that treated children with anxiety disorders. She believed that the description in the newspaper article of anxiety symptoms fit her child to a "T."

The presenting complaint is that Michael does not sleep in his own bed. He falls asleep in his parents' bed, is put in his own bed during the night in a room he shares with his five-year-old brother, but is never found in his own bed in the morning. During the night he makes his way into his parents' bed. If they remove him from their bed, they find him huddled in a corner of their room, or in a chair in their bedroom.

In addition, his mother describes herself as "a prisoner in my own home." Michael is afraid to stay home alone, and will not even go out of the apartment by himself to do simple things such as take out the garbage. He does not let his mother go into any room by herself, but insists upon staying with her. Because the mother does not allow Michael to be with her while she dresses or is in the bathroom, he stands outside the door, continuously asking when she will be out. She has learned to take care of her grooming in five-minute periods, which are the maximum he tolerates without becoming extremely upset. The difficulties began when, at age two, he started having tantrums when she went to the bathroom.
Furthermore, Michael has many numerous physical symptoms, such as stomach aches and headaches, that usually occur in the morning and are often accompanied by complaints that he is going to die and should be taken to the hospital. These never occur on weekends or during the summer, but only on school days. Yet, he has never refused to go to school.

His teacher describes Michael as doing little work in class and not turning in homework. She states, "He appears dejected, not a happy child and not a confident one. His work is messy and could be much better; he seems to have the capabilities of doing better." His performance in all subjects is considered at average or above-average level.

At the clinic Michael separates easily from his mother but wants to keep the office door open while being interviewed. He relates well initially, laughing easily while talking about school, which he says he likes and in which he feels he is doing well. His affect changes markedly when the topic turns to his feelings. He becomes difficult to draw out and states that he misses his mother in school, especially while staying with the baby-sitter after school until his mother comes home from work. He constantly worries about whether his mother will pick him up from the baby-sitter’s house. He says that at night he is plagued by scary thoughts about something happening to his parents and reports "I’m afraid I’ll never see them again." During the day he often worries about getting lost and what would happen to him if his mother died.
Case Vignette

Loretta, age seven and one-half months, was referred with her mother, Crystal, age 30, by the mother's attorney and by Loretta's pediatrician because Loretta did not respond to her name or to ordinary conversation. Her hearing, according to tests, was normal.

The mother's pregnancy had been planned and uneventful until two weeks before birth, when placenta previa was diagnosed. Delivery was by Caesarean section. Birth weight was 7 1/2 pounds; length was 21 inches. Loretta was discharged from the hospital at two days. Her mother, however, remained in the hospital for seven days because of fever, which responded to antibiotics, while Loretta was cared for at home by her father and a variety of relatives. The mother was weak and unable to care for her child and developed a spiking fever that required rehospitalization. She was referred for surgery for removal of a sponge that had been left in the abdomen at the time of the Caesarean section. The mother's recovery was again slow, and she did not return home until six weeks postpartum.

At two months Loretta was extremely quiet, apathetic, and weak and was not gaining weight. At home her mother became severely depressed and had dreams of Loretta's dying through some form of violence. She avoided holding Loretta until the baby was five months old, at which time her depression lifted and she began caring for the infant regularly.
When first seen, Loretta was well nourished and apparently well developed. However, she had a constantly serious expression and an extremely immature smile, with a partly open mouth and no upturning at the corners of the mouth. She did not respond to her name. She made few sounds, and it was difficult for her to maintain eye contact. According to her mother, Loretta had made no notable gains in physical development since she (the mother) has resumed care of the child when Loretta was five months of age.

Further follow-up of Loretta at nine months of age showed that her development had begun to proceed much more rapidly, and she was almost up to age level in fine-motor movements and socialization responses. She was beginning to show some evidence of separation anxiety. Her affect, however, remained blunted; and she was still a quiet, serious-looking, unresponsive child. She was not playful and did not show anticipatory extension of the arms when her mother reached for her.
Appendix A--Continued

Case Vignette

George, a thin, pale, five-year-old, was admitted to the hospital for a nutritional anemia that seemed to be due to his ingestion of paint, plaster, dirt, wood, and paste. He had had numerous hospitalizations under similar circumstances, beginning at 19 months of age, when he had ingested lighter fluid.

George's parents subsisted on welfare, and were described as immature and dependent. He was the product of an unplanned but normal pregnancy. His mother began eating dirt when she was pregnant, at 16 years of age. His father periodically abused drugs and alcohol.
Case Vignette

Sebastian, an only child of divorced parents, lives with his father, a chemistry professor. He was adopted as an infant and is now 14 years 3 months of age.

Sebastian's father had him examined by several medical specialists prior to the present consultation including a neurologist, a psychiatrist, and a nutritional expert.

Sebastian's problem was one of recurring tic-like movements of his head and neck, repetitive grunts and other rapid, purposeless movements of his limbs. Sebastian had been experiencing these symptoms for at least two years; they were worse when he was under stress. His father reported that the movements disappeared when he was asleep and that Sebastian seemed able at times to voluntarily control the movements sometimes for a day or more.
Appendix A—Continued

Case Vignette

An eight-year-old boy was taken by his parents to the pediatric emergency room at 12:30 A.M. The parents were very concerned because the child woke them up with a sudden, intense, bloodcurdling scream. They went to his room and found him sitting up in bed perspiring copiously, anxious, and trembling, with rapid breathing and "goose pimples." He kept putting his forefinger in his nose (an unusual gesture for him), and was quite disoriented and anxious, as if something terrible were going to happen. His speech could not be understood. He remained in this state for about ten minutes, despite his parents' efforts to calm him. Once in the car enroute to the hospital, he calmed down and became quite sleepy again.

When seen, the child was asleep and when awakened, resisted being examined. Physical examination was negative except for a pulse rate of 110/min and mildly wet pajamas due to excessive sweating.

The child's mother is afraid he may have had an epileptic fit, as an uncle of hers had; but she noticed he did not bite his tongue or wet himself during the episode, as her uncle used to do. There is no history of seizures or febrile convulsions. The child had occasional nightmares, at the age of four and a half, for a few months; but the mother thinks "this is different."
Case Vignette

A five-year-old boy was brought to the Child Guidance Center. After a considerable period of denial, his parents realized that he was not developing normally. Since age three, despite normal language development, he seemed to become distant from and uncommunicative with them. He was easily frightened, at times got angry for unexplained reasons, and at other times was observed totally engrossed in stereotyped rocking behavior in his room.
Case Vignette

George is a fourth grader who is having difficulty in school. He gets along well with other children but has poor academic performance. George is flunking reading and spelling and having difficulty in science. He is passing math, art, and physical education. On the Weschler Intelligence Scale for Children, he obtained a full scale I.Q. score of 100 with a verbal score of 95 and a performance score of 103. On an individual achievement test, George's reading comprehension score was at grade level 1.6, his spelling score was at grade level 2.0, and his math score was at grade level 3.2. There were no notable problems at home with the exception of the parent's difficulty getting George to do his homework.
Case Vignette

Bob is a 14-year-old junior high school student. A member of the school band, Bob is an average student whom his teachers describe as a "model citizen." Bob's parents brought him to Child Guidance for vocational testing. They were also concerned over a few instances where Bob "talked back" and his frequent mood changes.

Neither Bob nor any family member has received counseling for any reason, although a distant Aunt was said to be a little "depressed" from time to time.
Appendix B

Psychological Rating Scale for Diagnostic Classification of Children and Adolescents to be used with DSM-III.

Instructions

1. During clinical interview determine the child or adolescent's major problematic symptoms, behaviors, or characteristics.

2. Using the rating scale, sequentially review items 1-64. If a problematic symptom, behavior, or characteristic is represented by an item place a check mark in the box or boxes corresponding to that item on the rating scale form.

3. Columns (A-J) found to the right of the item descriptors represent the clinical syndromes for infancy, childhood, and adolescence found in DSM-III. Upon completion of items 1-64, sum the check marks for each of the columns (A-J). Check marks placed in boxes with the weighting (2) are counted as two check marks when summed.

4. Refer to the summary page. Each column (A-J) on the rating scale form is represented on the summary page by a clinical syndrome. If a column total is equal to or greater than the corresponding score representing "some evidence" or "substantial evidence" of that clinical syndrome place a circle around that particular score on the summary page. A column total must equal or exceed the "substantial evidence" criterion score found on the summary page. A score which exceeds "some evidence" but does not reach the criteria for "substantial evidence" is recorded as representing "some evidence" of a clinical syndrome.

5. When "substantial evidence" of a clinical syndrome exists refer to the accompanying Guidelines for Coding to determine the specific disorder and corresponding DSM-III code number. This is done for each syndrome found to have "substantial evidence" for its presence. Using the data derived from the rating scale the appropriate DSM-III multiaxial diagnosis may now be determined.
1. Social skills are inappropriate or extremely disturbed for the child's age.

2. Aggressive behavior; temper tantrums; frequent violations of minor rules.

3. Impulsive, acts without thinking; unable to wait for turn during group activities; has difficulty remaining seated.

4. Fails to feel affection or empathy for others; manipulates people for favors but doesn't reciprocate.

5. Exhibits aggressive behavior which violates other's rights, e.g., theft, physical violence, rape, mugging.

6. Behavior conflicts with age appropriate norms, e.g., persistent truancy, substance abuse, running away, vandalism, frequent fighting, and serious lying.

7. Displays precocious sexual activity; may be involved with a gang; remains only superficially attached to a few people.

8. Exhibits constant clinging to or "shadowing" parent; avoids social situations and strangers; refuses to travel alone, attend camp, stay overnight with friends or run errands; fails to play cooperatively; lacks interest in people.
9. Unassertive and lacks self-confidence; often seen as a loner with no close friend and little desire to socialize; appears aloof, withdrawn, seclusive, self-absorbed.

10. Extreme shyness; often the "scapegoat;" daydreams excessively; generally avoids nonfamilial social contact.

11. Exhibits little response to caretaker, e.g., fails to reach out in anticipation of being picked up; extreme lack of interest in the environment.

12. Conceals or hoards food; prepares elaborate meals for others while eating only diet foods.

INTELLECTUAL AND ACADEMIC FUNCTIONING

13. Exhibits significantly subaverage general intellectual functioning.

14. Poor academic achievement; often suspended from school; displays poor tolerance for frustration.

15. Easily distracted, seems not to be listening; poor concentration, can't stay on task and makes careless errors; fails to complete assignments.

16. Has no appreciation of real danger, e.g., will put hand in flame, walk into oncoming traffic; preoccupied with morbid thoughts, bizarre ideas, and fantasies.

17. Extremely overconcerned with competence.
18. Unable to choose a life pattern; displays extreme conflicts over a career choice.

19. Significant impairment in arithmetic or reading skills (below intellectual capacity) not a function of age or inadequate schooling, e.g., poor oral reading with omissions and distortions of words; makes errors when spelling to dictation; discriminates sounds poorly.

**PHYSICAL OR PERCEPTUAL-MOTOR INVOLVEMENT**

20. Poor coordination, e.g., hand-eye, with possible visual or hearing problems; stereotyped movements; prone to accidents.

21. Excessive motor activity, e.g., running and climbing; purposeless behavior; fidgety and restless during sleep.

22. Complains of stomach aches, nausea, headaches or dizziness when separation from caretaker is anticipated or occurs; marked feelings of tension, unable to relax.

23. Experiences difficulty going to sleep; nightmares; lump in throat; shortness of breath; gastrointestinal upsets; nailbiting; feelings of being "nervous" are common.

24. Deficit in physical development and failure to thrive - infant doesn't smile or visually track; weak cry, excessive sleep, poor muscle tone, rumination, hypomotility, weak rooting and grasping response commonly seen.
25. Refusal to maintain minimal body weight; excessive weight loss; amenorrhea; eating binges and self-induced vomiting.

26. Excessive concern about body weight; continual dieting and overuse of diuretics and cathartics; will hide to binge.

27. Persistent eating of non-nutritive substances, e.g., hair, paint, leaves, bugs, without a food aversion.

28. Repeated regurgitation of food with chewing and reswallowing of the partially digested food; weight loss; no evidence of nausea - a period of normal functioning precedes this behavior.

29. Involuntary, repetitive, rapid movements (tics), e.g., eye blinks-head, face, torso, or vocal tics (barks, grunts, or curses); tics worsen during stress and disappear with sleep.

30. Bangs head, rocks, makes repeated hand motions; repeats own words; imitates other's movements; sniffs, clears throat, protrudes tongue; touches things impulsively.

31. Involuntary voiding of urine without a physical disorder.

32. Voluntary or involuntary passing of feces in inappropriate places without a physical disorder.

33. Repeatedly leaves the bed and walks about; may eat or dress; unresponsive to efforts to awaken.
34. Abrupt awakening from sleep with a panicky scream; rapid breathing and heart beat with profuse sweating; confused disoriented and unresponsive to comforting.

35. Indifference or aversion to affection or physical contact; won't cuddle or make eye contact.

36. Fascination with movement, e.g., spinning objects, or buttons; extremely attached to odd objects, e.g., a rubberband; exhibits peculiar nervous habits such as hair-pulling.

37. Displays inability to localize sound; deficits in sensory perception occur; partial hearing defects may exist.

DEVELOPMENTAL CONCERNS

38. Independent functioning lags behind age group.

39. Developmentally inappropriate inattention.

40. Appears overly mature with "precocious" concerns; excessive need for reassurance about worries.

41. Exhibits no real sense of self; functions poorly due to identity conflicts.

LANGUAGE AND SPEECH

42. Delayed language acquisition or absence of language.

43. Appears inarticulate or mute in stressful social situations.
44. Continuous refusal to speak in social situations while able to understand and speak if so desiring.

45. Frequent repetitions or prolongations of sounds, syllables, or words; disruption of rhythmic flow of speech with difficulty speaking in class.

46. Little or no verbal or nonverbal language; can't name objects; uses idiosyncratic words or phrases.

47. Failure to develop consistent articulations of speech sounds, e.g., r, sh, ch, th, f, z, and l; speech sounds like "babytalk."

48. Failure to develop vocal expression of language while able to understand; immature articulation and very restricted vocabulary.

49. Failure to develop comprehension and vocal expression of language.

AFFECTIVE BEHAVIOR

50. Irritability; low self-esteem.

51. Labile mood; low frustration tolerance; lack of response to discipline; behaves in an obstinate, bossy, stubborn manner.

52. Perfectionistic; self-doubting; in need of constant attention; demanding.

53. Unusually conscientious, conforming, and eager to please.
54. Belligerent to social demands; apathetic mood; absent minded; sensitive to criticism.

55. Persistent oppositional attitude; provocative with people in authority; disobedient; negativistic and argumentative.

56. Depressed mood with self-depreciating thoughts; obsessive self-doubting.

57. Extreme reactions to minor environmental changes; insistence on following a specific routine, e.g., at bedtime or meal time; cries, giggles or laughs without apparent reason.

58. No feelings of guilt or remorse over behavior; little concern for others.

ANXIETY AND/OR FEARS

59. Very anxious and panicky when away from home or parents.

60. Morbid fears of accidents or illness; fear of the dark; fears of getting lost.

61. Excessive worrying, e.g., about parent's health; acutely homesick when away from home; excess worry about future events.

62. Mild anxiety and depression.

63. Intense fear of becoming obese; "feels fat" even when emaciated; constantly checks body size in mirror; fears being unable to stop eating.
64. Sudden excessive anxiety; unexplained panic attacks and rage reactions.

Total the number of symptoms under each letter.
Appendix D

AXIS I

CLINICAL SYNDROME

<table>
<thead>
<tr>
<th>Mental Retardation</th>
<th>Attention Deficit Disorder</th>
<th>Conduct Disorder</th>
<th>Anxiety Disorders of Infancy, Childhood, or Adolescence</th>
<th>Other Disorders of Infancy, Childhood, or Adolescence</th>
<th>Eating Disorders</th>
<th>Stereotyped Movement Disorders</th>
<th>Other Pervasive Developmental Disorders</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>
</tr>
</tbody>
</table>

**Substantial Evidence**

4+  6+  8+  12+  10+  2+  2+  2+  4+  2+

**Some Evidence**

3+  3+  4+  4+  5+  0  0  0  3+  1+

AXIS III: PRESENCE OF MEDICAL HISTORY

- with possible related symptoms
- with definite supportive medical findings

AXIS IV: RATING OF SEVERITY OF PSYCHOSOCIAL STRESSORS

- 1 - None
- 2 - Minimal
- 3 - Mild
- 4 - Moderate
- 5 - Severe
- 6 - Extreme
- 7 - Catastrophic
- 0 - No information

AXIS V: HIGH 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 represent either some evidence, e.g. (A) with 3+ symptoms or substantial evidence, e.g. (A) with 4+ symptoms.*
Appendix E

Psychological Rating Scale for Diagnostic Classification of Children and Adolescents Procedural Guidelines for Coding.

MENTAL RETARDATION

A. Mental Retardation: #1, #13, #38, #42 Significantly subaverage intellectual functioning defined as an IQ of 70 or below; personal independence and social responsibility are below that expected for age and cultural group.

Onset: Before the age of 18.

Course: (5th digit) May be chronic and without remission if specific biological abnormality is present or self-limited in mild forms. If behavioral symptoms requiring attention or treatment exist that are not part of another disorder code "1" otherwise code "0."

Types of Mental Retardation

1. Mild Mental Retardation: Meets criteria of mental retardation
   317.0(X)
   -- IQ 50-70
   -- educational category "educable"
   -- other features #38, #50
   -- Minimal sensorimotor impairment

2. Moderate Mental Retardation: Meets criteria of mental retardation
   318.0(X)
   -- IQ 35-49
   -- educational category "trainable"
   -- other features #1, and #20, as well as, poor social awareness
Appendix E—Continued

3. Severe Mental Retardation:  Meets criteria of mental retardation
   318.1(X)
   -- IQ 20-34
   -- other features #2, #42, as well as, poor motor development

4. Profound Mental Retardation:  Meets criteria of mental retardation
   318.2(X)
   -- IQ below 20
   -- other features #1, #2, #20, as well as, minimal capacity for sensorimotor functioning

5. Unspecified Mental Retardation:  Strong presumption of mental retardation exists
   319.0(X)
   -- the individual is untestable by standard intelligence tests

ATTENTION DEFICIT DISORDER

A. Attention Deficit Disorder:  #3, #15, #21, #39
   Attentional difficulties are virtually always present; excess motor activity may exist concurrently.

   Onset:  Prior to age 7.

Types of Attention Deficit Disorder

1. Attention Deficit Disorder with Hyperactivity:  314.01
   Meets criteria of A.D.D.
   -- #3, #15, #21, and #39
   -- duration of at least 6 months
   -- signs of the disorder may be absent when child is in a new or one-on-one situation
   -- group situations are particularly difficult, e.g., in the classroom
2. Attention Deficit Disorder without Hyperactivity: 314.00
Meets criteria of A.D.D. except for the absence of hyperactivity
-- associated features and impairment may be milder

3. Attention Deficit Disorder, Residual Type: 314.80
Information from individual or family members indicates the person once met the criteria of A.D.D. with hyperactivity
-- hyperactivity no longer exists, however, there may be some impairment in social or occupational function due to #3, #15, and #39

CONDUCT DISORDER

A. Conduct Disorder: #4, #5, #6, #7, #50, and #58
Violation of basic rights of others or age-appropriate societal norms or rules which occur repetitively and persistently; more serious than ordinary childhood or adolescent mischief and pranks.

Onset: Prepubertal for the Undersocialized type; pubertal or post-pubertal for the Socialized type.

Duration: At least 6 months for both aggressive and nonaggressive conduct.

Types of Conduct Disorder

1. Conduct Disorder, Undersocialized, Aggressive: 312.00
Repetitive and persistent pattern of aggressive conduct
-- basic rights of others are violated as seen by #5
-- #4 and no evidence of social attachments, such as peer-group friendships, showing concern for other's welfare, or extending self to others for no obvious benefit
2. Conduct Disorder, Undersocialized nonaggressive: 
   312.10
   Repetitive and persistent pattern of nonaggressive conduct
   -- basic rights of others or age-appropriate societal norms or rules are violated as seen by #6
   -- #14, #20, and #50, as well as, no evidence of social attachments, e.g., friendships of over 6 months, showing concern for other's welfare, avoiding blaming or informing on companions

3. Conduct Disorder, Socialized, Aggressive: Meets criteria or Conduct Disorder Aggressive subtype
   -- shows evidence of social attachment to other's, e.g., #7, has one or more friendships of over 6 months duration, feels guilt or remorse appropriately, displays concern for other's welfare

4. Conduct Disorder, Socialized, Nonaggressive: Meets criteria of Conduct Disorder Nonaggressive subtype
   -- shows evidence of social attachment, such as, maintaining friendships, helping others, feeling guilt or remorse appropriately

5. Atypical Conduct Disorder: Violation of basic rights of others or major age-appropriate societal norms or rules occur but cannot be classified as one of the specified subtypes
   -- a residual category

ANXIETY DISORDERS OF CHILDHOOD OR ADOLESCENCE

A. Disorders in which anxiety is the predominant clinical feature, e.g., #23, #59, #60, #61

Types of Anxiety Disorder
1. Separation Anxiety Disorder: Excessive anxiety concerning separation from caretakers manifested by at least 3 of the following: #8, #22, #23, #59, #61, and social withdrawal, apathy, sadness, or concentration difficulties when not with a major attachment figure — duration of at least 2 weeks

Course: Periods of exacerbation and remission over several years

2. Avoidant Disorder of Childhood or Adolescence: Persistent and excessive shrinking from contact with strangers, e.g., #8 — desires affection and acceptance — behavior is severe enough to interfere with social functioning in peer relationships — duration at least 6 months

Age: At least 2 1/2 years old

3. Overanxious Disorder: Excessive worrying and fearful behavior without specific focus — behavior is not due to a recent psychosocial stressor — essential features are #17, #22, #23, #40, and #61, as well as, marked self-consciousness regarding embarrassment or humiliation — duration at least 6 months — not due to another mental disorder

OTHER DISORDERS OF INFANCY, CHILDHOOD, OR ADOLESCENCE

Types of Other Disorders

1. Reactive Attachment Disorder of Infancy: Predominant features include #11, and #24
Appendix E--Continued

69

-- lack of care that leads to the development of affectual bonds to others, e.g., gross emotional neglect, imposed social isolation

-- at least three symptoms as seen in §24

-- weight loss or failure to gain weight not due to a physical disorder

Age: Prior to 8 months of age

2. Schizoid Disorder of Childhood or Adolescence: Defect in the capacity to form social relationships, not due to another mental disorder

-- essential features include #9, #10, and child derives no pleasure from the usual peer interactions

-- duration at least 3 months

-- not due to Pervasive Developmental Disorder, Conduct Disorder, or any psychotic disorder

3. Elective Mutism: Essential features include #10, and #44

-- not due to another mental or physical disorder

Age: Usually before 5 years old

4. Oppositional Disorder: Child displays a pattern of behavior of at least 6 months duration which includes these features: #2, #54, #55

-- no violations of basic rights of others or major age-appropriate societal norms or rules

Onset: After 3 years and before age 18

5. Identity Disorder: Severe subjective distress regarding inability to reconcile aspects of the self into a relatively coherent and acceptable sense of self
Appendix E—Continued

-- major features #18, #41, #62
create improved social or
occupational functioning
-- duration of at least 3
months
-- not due to another mental
disorder

EATING DISORDERS

A. Gross disturbances in eating behavior

B. Simple obesity is not included.
It is not generally associated with any distinct psycho-
logical or behavioral syndrome.

1. Anorexia Nervosa: Primary features include #12,
307.10
   #25, #56, and #63
   -- disorder cannot be accounted
   for by a known physical dis-
   order
   -- stressful life situation may
   predispose

   Onset:         Early to late adolescence
   Course:       Usually a single episode with
                  full recovery, however, may be
                  unremitting until death by
                  starvation occurs

2. Bulimia: Episodic binge eating accompanied by an
307.51
   awareness that the eating pat-
   tern is abnormal
   -- at least 3 features from the
   following:  #12, #25, #26,
   #56
   -- bulimic episodes are not due
to Anorexia Nervosa or any
known physical disorder

   Onset:         Adolescence to early adult life
   Course:       Usually chronic and intermit-
tent over many years

3. Pica: Persistent eating of nonnutritive substance
307.52
   -- essential features seen in
   #27
   -- duration of at least 1 month
   -- not due to another mental
disorder
Appendix E--Continued

Onset: 12 to 24 months or earlier

Course: Usually remits in childhood, but may continue into adolescence

4. Rumination Disorder of Infancy: Essential features
   found in #28
   -- infant seems to gain satisfaction from this activity
   -- weight loss or failure to gain expected weight

Onset: Starts between 3 and 12 months of age

Course: Potentially fatal; spontaneous remissions are thought to be common

5. Atypical Eating Disorder: Residual category for eating disorders that cannot be adequately classified in previous categories

STEREOTYPED MOVEMENT DISORDERS

A. Stereotyped Movement Disorders (tics): Essential features include #29, #30, and #56
   -- abnormality of gross motor movement

   It is unknown whether the three tic disorders represent distinct conditions or a continuum of severity.

1. Transient Tic Disorder: #29 carries essential features
   -- individual can suppress movements voluntarily for minutes to hours
   -- intensity will vary
   -- duration of at least 1 month, but not more than 1 year

Onset: During childhood or early adolescence

Course: Tic may disappear permanently or recur during periods of stress
2. Chronic Motor Tic Disorder: Essential features seen in #29
   - tics usually involving no more than 3 muscle groups at any one time
   - duration of at least 1 year
   - intensity varies and tics may be voluntarily suppressed for periods of time

   Onset: Either in childhood or after age 40
   Course: Tends to be chronic

3. Tourette's Disorder: #29 and #56 portray the essential features
   - symptoms are exacerbated by stress
   - nonspecific EEG abnormalities and soft neurological signs may be present
   - duration of greater than one year
   - multiple muscle groups are affected
   - multiple vocal tics occur

   Onset: Between 2 and 15 years of age
   Course: Usually lifelong with brief periods of remission; disorder may remit prior to adulthood in rare cases

4. Atypical Tic Disorder: Category for tics not adequately classified in previous categories

5. Atypical Stereotyped Movement Disorder: Primarily for conditions such as #30
   - distinguishable from tics due to the voluntary nature of the movements
   - movements are not spasmodic
   - the individual may appear to derive enjoyment from the repetitive activities
   - may be seen concurrently with Mental Retardation or Pervasive Developmental Disorders
A. Disorders with physical manifestations: Predominant disturbance is in a physical function; not generally associated with mental disorders

Types of Other Disorders with Physical Manifestations

1. Stuttering: Essential features evident in #45 and 307.00
   -- intensity varies with the situation and is most acute under conditions of high stress, e.g., job interviews
   -- often obscure during oral reading, singing, or talking to pets

Onset: Usually before age 12; peaks of onset occur at ages 2 to 3 1/2 and 5 to 7 years

Course: Usually chronic with periods of remission; some children may recover spontaneously

2. Functional Enuresis: #31 demonstrates primary features
   -- child may feel ashamed and avoid situations possibly embarrassing
   -- may occur during the day or night
   -- incidents of at least twice a month for ages 5 and 6; once a month for older children
   -- not due to physical disorder

Types of Functional Enuresis

a. Primary: enuresis has not been preceded by a period of urinary continence for at least one year

b. Secondary: enuresis has been preceded by urinary continence for at least one year

Both types may be nocturnal (passage of urine during sleep only) or diurnal (passage or urine during waking hours) or both.
Appendix E—Continued

Onset: Primary Functional Enuresis begins by age 5
Secondary Functional Enuresis begins between ages 5 and 8

Course: Most children attain continence by adolescence

3. Functional Encopresis: Primary features are seen in #32
   -- shame and social avoidance accompany this disorder
   -- not due to physical disorder

Types of Functional Encopresis

a. Primary: Begins by age 4
b. Secondary: Begins between the ages of 4 and 8

Onset: As noted in "Types"

Course: Rarely becomes chronic

4. Sleep Walking Disorder: Essential features seen in #33
   -- episode may end prior to walking stage
   -- poor motor coordination during walking
   -- amnesia for events upon awakening
   -- increased incidence with stress, fatigue, or use of sedatives

Onset: Begins usually between the ages 6 and 12

Course: May last several years; most individuals are asymptomatic by their 20's

5. Sleep Terror Disorder (Pavor Nocturnus): Essential features are seen in #34
   -- episode usually occurs between 30 and 200 minutes after sleep onset
   -- intense anxiety, agitation, and perseverative motor movements accompany the episode
Appendix E—Continued

-- morning amnesia for the episode is typical
-- frequency increases with stress, fatigue, or with bedtime dose of tricyclic antidepressant or neuroleptic

Onset: Usually begins between 4 and 12 years of age

Course: In children the disorder usually gradually disappears in early adolescence

PERVASIVE DEVELOPMENTAL DISORDERS

A. Pervasive Developmental Disorders: Distortions in the development of multiple basic psychological functions that are involved in the development of social skills and language, e.g., attention, of social skills and language, e.g., attention, perception, reality testing, and motor movement
-- severe qualitative abnormalities that are not normal for any stage of development are displayed
-- essential features may be seen in #1, #16, #35, #36, #42, #46, #57, and #64

5th Digit: Use for all Pervasive Developmental Disorders to indicate whether the full syndrome is present (code = 0) or whether the full syndrome occurred previously with the individual now having only residual symptoms, e.g., social withdrawal, or eccentric behavior (code = 1)

1. Infantile Autism: Essential features seen in #8, 299.0(X)
-- may display extraordinary long-term memory feats
-- mood lability may occur
-- extreme variability in intellectual functioning with symbolic or abstract thought especially impaired
Appendix E—Continued

Onset: Always before 30 months

Course: Chronic; one child in 6 will make adequate social/occupational adjustment

Types of Infantile Autism

A. Infantile Autism, Full Syndrome Present: Currently meets criteria for Infantile Autism

B. Infantile Autism, Residual State: Current clinical picture no longer meets full criterion for Infantile Autism, but signs of the illness continue to be present

2. Childhood Onset Pervasive Developmental Disorder: 299.9(X) Profound disturbance in social relations and multiple oddities of behavior as seen in the following, #1, #8, and #64

-- hyper or hypo sensitivity to sensory stimuli
-- mutilation may occur
-- absence of hallucinations, delusions, or loosening of associations

Onset: After 30 months of age and before 12 years of age

Course: Chronic; prognosis better than that of Infantile Autism

1. Childhood Onset Pervasive Developmental Disorder, 299.90

2. Childhood Onset Pervasive Developmental Disorder, 299.91
Appendix E—Continued

3. Atypical Pervasive Developmental Disorder: Use for children with similar features of developmental distortions who cannot be classified as Infantile Autism or Childhood Onset Pervasive Developmental Disorder

SPECIFIC DEVELOPMENTAL DISORDERS (AXIS II)

A. Specific Developmental Disorders:
Disorders of specific areas of development not due to another disorder. Each aspect of development is related to biological maturation
-- a particular child may have more than one Specific Developmental Disorder
-- no indication that these children will "catch-up" with time; signs of the disorder may continue into adulthood
-- essential areas of deficit include #19, #47, #48, and #49

Onset:
Related to the ages at which each area of functioning is expected to begin to develop

Course:
The disturbance is stable during childhood and adolescence; signs of the disorder may be seen in adult life

1. Developmental Reading Disorder: Primary feature seen in #19
-- has been referred to as "dyslexia"
-- 1-2 year discrepancy in reading skills for ages 8 to 13 is significant
-- performance is determined on standardized, individually administered tests of reading skill
2. Developmental Arithmetic Disorder: Primary feature
   included in #19
   -- performance is significantly below intellectual capacity
   -- reading and spelling problems may exist concurrently
   -- performance is determined on standardized, individually administered tests of arithmetic achievement

3. Developmental Language Disorder
   315.31

   Types of Developmental Language Disorder

   a. Developmental Language Disorder: Expressive Type
      #48 and slight lags in achieving developmental milestones
      -- tasks involving perceptual skills may show impairment
      -- not due to Mental Retardation, Childhood Onset Pervasive Developmental Disorder, hearing problem, or trauma

   b. Developmental Language Disorder: Receptive Type
      #49, as well as, deficits in sensory perception and sequential recall
      -- partial hearing defect for pure tones and sound localization are common
      -- not due to trauma, Mental Retardation, or Childhood Onset Pervasive Developmental Disorder

4. Developmental Articulation Disorder: Essential features seen in #47
   -- vocabulary and grammatical structures are within age norms
   -- includes "lalling" and "lisping"
   -- not due to Developmental Language Disorder, Mental Retardation, Childhood Onset Pervasive Developmental Disorder, or physical disorder
5. Mixed Specific Developmental Disorder: More than one Specific Developmental Disorder exists, but none predominates -- delayed skills are impaired to the relatively same degree

6. Atypical Specific Developmental Disorder: Residual category -- for use when there is a Specific Developmental Disorder not covered by previous specific categories
Dear Parent:

As a part of your child or adolescent's assessment at Dallas County Mental Health / Mental Retardation Center two interviewee/examiners will complete a rating scale currently under development. The purpose of this research is to provide mental health professionals with a reliable and convenient means of determining a child or adolescent's specific problem. A determination of this nature may facilitate a more rapid beginning of appropriate therapy.

There are no risks whatsoever to your child or adolescent due to the non-intrusive nature of the research. The rating scale instrument is being completed for research purposes only and will in no way interfere with the Center's normally thorough assessment procedures.

Your complete confidentiality is insured as at no time will you or your child or adolescent's name be required for the completion of the research.

You are free to refuse to have your child or adolescent rated with the assurance that this will in no way interfere with appropriate service being provided by the Center. Your consent shall be limited to the duration of this study and you may revoke consent at any time during this period.

Thank You!

I agree to allow my child or adolescent to be rated:

Signed: __________________________

Date: __________________________
Appendix G

Rater _____
Case _____

The Psychiatric Rating Scale for Diagnostic Classification Of Children and Adolescents

MULTIAXIAL DIAGNOSIS

Axis I:

Axis II:

Axis III:

Axis IV: Psychosocial Stressors:
  Severity:

Axis V: Highest level of adaptive functioning past year:

______________________________

Patient: Age ______
  Sex ______
  Race ______

______________________________

Diagnosis derived by traditional psychometric instruments:
References


Mezzich, J. E. (1979). Patterns and issues in multiaxial psychiatric diagnosis. Psychological Medicine, 9, 125-137.


