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INTERRATER RELIABILITY OF THE PSYCHOLOGICAL RATING  
SCALE FOR DIAGNOSTIC CLASSIFICATION

THESIS

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By

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The poor reliability of the DSM diagnostic system has been a major issue of concern for many researchers and clinicians. Standardized interview techniques and rating scales have been shown to be effective in increasing interrater reliability in diagnosis and classification.

This study hypothesized that the utilization of the Psychological Rating Scale for Diagnostic Classification for assessing the problematic behaviors, symptoms, or other characteristics of an individual would increase interrater reliability, subsequently leading to higher diagnostic agreement between raters and with DSM-III classification. This hypothesis was strongly supported by high overall profile reliability and individual profile reliability. Therefore utilization of this rating scale would enhance the accuracy of diagnosis and add to the educational efforts of technical personnel and those professionals in related disciplines.

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INTERRATER RELIABILITY OF THE PSYCHOLOGICAL RATING  
SCALE FOR DIAGNOSTIC CLASSIFICATION

Psychiatric diagnosis and classification have been challenged by much controversy and criticism. The American Psychiatric Association's Diagnostic and Statistical Manuals of Mental Disorders (DSM-I and DSM-II) have been utilized for most of the research in this area. The question of interrater reliability (consistency with which labels are assigned by different professionals) has been a major issue of concern for many researchers and clinicians.

Much of the research relating to the DSM system has centered on its reliability and validity. Reliability generally refers to the consistency with which subjects are classified and validity refers to the utility of the system (Spitzer & Fleiss, 1974). Spitzer and Fleiss (1974) state that "there is no guarantee that a reliable system is valid, but an unreliable system must be invalid." Therefore reliability, especially interrater reliability seems to be the most important component of a useful system.

Generally, the results of years of study have indicated the poor reliability of the DSM diagnostic system

(Foulds, 1965; Hock & Zubin, 1953; Schmidt & Fonda, 1956; Spitzer & Fleiss, 1974; Zigler & Phillips, 1961). In one study of diagnostic discrepancy, Ward, Beck, Mendelson, Mock, and Erbaugh (1962) found that inadequacy of the nosological system (DSM-I) accounted for most (62.5 percent) of the diagnostic differences among raters. Ullman and Krasner (1975) point out that the major reasons for the inadequacy of the system involve inexactness of the definitions. They believe that the material is too brief and key terms are not defined. The poor reliability and insufficiency of the system have created a growing reluctance among some professionals to use this type of diagnostic criteria. Some critics have gone to the extreme of suggesting abandonment of the psychiatric diagnosis altogether (Menninger, 1963; Szasz, 1969; & Sharma, 1970).

Despite the problems involved in psychiatric classification and diagnosis, the concept remains widely supported and is regarded as an essential and fundamental task. Helzer, Robins, Taibleson, Woodruff, Reich and Wish (1977) state that "a classification system enables us to accumulate and codify our own clinical experience, to share the collective experience with others, and to pass that to students in a systematic way." Diagnostic classification is also important in research, etiology, course of illness, prediction, and treatment (Spitzer & Fleiss, 1974; Woodruff, Goodwin & Guze, 1974). Grinker

(1977) has stated that there can be no science without diagnosis and Kendall (1975) has concluded that diagnosis is "inevitable." Blashfield and Graguns (1976) note "the DMS-II is the near universal basis of diagnostic action in the mental hospitals and the courts of the country." There is no reason to doubt that the current DSM-III will be just as widely utilized. As Smith (1966) points out, "even if a new diagnostic system were devised and judged to be adequate, it would take years for it to gain widespread acceptance and use." Subsequently, psychiatric classification will continue to be made and the DSM classification system is currently utilized the most for this purpose.

The DSM-III is the newest addition to the DSM system. Work began on the DSM-III in 1974 and it was published for use in 1980. A special task force was appointed to formulate this manual, in an effort to alleviate and clarify some previous problems associated with the DSM-II. The DSM-III includes expanded descriptions of the disorders, a multiaxial system and some category changes. "Field trials" were conducted over several years using drafts of the DSM-III. Spitzer, Forman, and Nee (1979) report that in phase one of the field trials, the overall kappa coefficient of agreement for Axis I diagnoses was .78 for joint interviews and .66 for diagnoses made after separate interviews. For Axis II

(personality disorders and specific developmental disorders) the coefficients for agreement were .61 and .54. They claim that the reliability of the DSM-III is greater than that previously achieved with DSM-II. They state the possible reasons for higher reliability as changes in the classification itself, the separation of Axis I from Axis II, the systematic description of the various disorders and the inclusion of diagnostic criteria. Although the changes made in the DSM-III may contribute to improved reliability of the system, more research must be conducted to determine the extent of the increase. The improvement in reliability may not be significant because of other factors. Such factors as insights, sophistication of the rater, rater bias, and theoretical persuasion also affect interrater reliability (Pumroy & Kogan, 1955).

Standardized interview techniques and rating scales have been developed in an attempt to diminish interrater discrepancies in classification and diagnosis. Helzer, Clayton, Pambakian, Reich, Woodruff, and Reveley (1977) state that "the unstructured interview probably increases the chance of bias in both the collection and interpretation of information." Spitzer and Endicott (1968) support this contention and assert that "part of the present well documented unreliability of psychiatric diagnosis lies in the variability in the operations by which clinicians use the raw data of observation to



make a diagnosis." A clinician may label the same set of behavioral pathology differently on different occasions because he or she does not use a consistent set of decision rules to integrate the data (Beck et al. 1962; Gauron & Dickinson, 1966). Spitzer and Endicott (1968) subsequently developed "DIAGNO," a computer program that uses the Psychiatric Status Schedule (PSS) to make diagnoses. It offers twenty-five standard APA diagnoses and qualifying phrases, as well as two unofficial diagnoses (not ill and nonspecific illness with mild symptomatology). This system has been found to be useful, but does not include categories such as "personality disorders" and "psycho-physiological disorders." This system is available to a limited population with access to computers

Wing, Birley, Cooper, Graham, and Isaacs (1967) developed an instrument for structuring a clinical interview called the Present State Exam (PSE). This interview form inquires about the psychological functioning of an individual within the month prior to the exam. Spitzer and his group also have published several interview formats, the most recent one called the Schedule for Affective Disorders and Schizophrenia (SADS). A computer analysis can be used with both of these groups to derive different diagnoses. Duckworth and Kedward (1978) found that "the use of standardized interview techniques and categorization by computer yield reliable symptom ratings and precise diagnosis."

Weitzel, Morgan, & Guyden et al. (1973); Gurland, Yorkston, & Stone et al. (1972); Climent, Plutchik, Estrada et al. (1975); and Smith (1966) have also devised structured interview forms and methods for diagnosing.

The rating scales were conceived as "mechanisms for describing, in form amenable to further quantitative evaluation, the symptoms and signs upon which psychiatric diagnoses have traditionally been based" (Overall, Hollister, & Pichot, 1967). Wittenborn (1951) was one of the first to develop a rating scale for psychiatric classification. His goal was to devise a rating scale procedure by which a psychologist, psychiatrist, nurse, or other competent observer could prepare a profile which would indicate the degree to which the patients symptom manifestations resembled each of the various symptom patterns shown to exist among mental patients. He developed the scales by rating a heterogeneous sample of veteran patients. He then intercorrelated the scales and these were factor analyzed. He arrived at seven clusters of symptoms and developed a profile which indicated the degree to which the patients symptom manifestations resembled the symptom clusters existing among mental hospital patients. Wittenborn and Mettler (1951), and Machir and Russell (1963) found high interrater agreement with these scales when the raters were properly trained. Pumroy and Kogan (1955), however, did not find

as high interrater reliability and the amount of agreement on individual patients was relatively low. Helzer et al. (1977) criticized the Wittenborn scales because they were generally not used to assign a patient to diagnostic categories with which psychiatrists were most familiar. In addition, symptoms derived on the basis of a factor analysis of patient responses do not necessarily take the entire clinical picture into account (Wing et al. 1967). Other rating scales include Lorr, Klett, and McNair's Interpersonal Behavior Inventory (1963); Overall, Hollister, and Pichot's (1967) Brief Psychiatric Rating Scale (BPRS), and Beitchman, Dielman, Landis, Benson, and Kemp's (1978) Group for the Advancement of Psychiatry (GAP) diagnostic categories. These scales, although economical and convenient to use, have similar utility problems as the Wittenborn scales. Basically, they use limited diagnostic categories that do not always coincide with the widely accepted DSM system.

The purpose of the present study was to establish the Psychological Rating Scale for Diagnostic Classification as a reliable, convenient and structured method of diagnosis and classification of individuals. This study determined the interrater reliability of this instrument for determining the presence of any of nine clinical syndromes. It was hypothesized that through utilization of this instrument, a clinician can rate the problematic behaviors, symptoms, or other characteristics of an

individual and use these ratings to determine a diagnostic classification in agreement with a DSM-III diagnosis.

### Method

#### Subjects

The following study utilized ten different case vignettes, one for each of the nine major clinical syndromes considered by this instrument, and one "control" vignette with no pathology (see Appendices A through J). The nine vignettes were obtained from the DSM-III Training Guide and the Control Case was composed for use in this study.

#### Instrument

The Psychological Rating Scale for Diagnostic Classification is based on the description of categories and diagnostic criteria as listed in the DSM-III (see Appendix K). It is comprised of seventy significant problematic behaviors, symptoms, or personality characteristics that are briefly described and listed. These are conveniently arranged under the identifying categories of Interpersonal Relationships, Intellectual and Memory Functioning, Perceptual Involvement, Substance Use, Affective Behavior, Physical or Medical Concerns, Speech, and Anxiety and/or Fears. To the right of the behavioral descriptions are nine columns (A-I) which correspond to

nine different major clinical syndromes or disorders: Organic, Substance Abuse, Psychosis, Paranoid, Affective, Anxiety, Somatoform, Dissociative, and Personality Disorders (Axis II). The DSM-III listing of Psychological Factors Affecting Physical Condition and Somatoform Disorders are combined under the category "Somatoform." Psychotic Disorders Not Elsewhere Classified and Schizophrenic Disorders are combined in the category "Psychosis." Disorders Usually First Evident in Infancy, Childhood or Adolescence, Psychosexual Disorders, Factitious Disorders, Disorders of Impulse Control Not Elsewhere Classified, and Adjustment Disorders are not currently included for use with this instrument.

Written instructions were available to the raters (see Appendix L). To use the instrument, the rater determined the relevant and problematic behavior or characteristics of a case subject and placed a checkmark in the appropriate column beside each item. The checkmarks were weighted when applicable and totaled in each column. On the bases of these totals, the rater identified the case subject as having "some" evidence or "substantial" evidence of one or more of the clinical syndromes (see Appendix M). With this information, the rater determined the specific disorder and code number by utilizing addendum material (see Appendix N). Additional information was available for determining Axis' III, IV, and V for the case subject (see Appendix M).

### Raters

Ten graduate students in the psychology program at North Texas State University served as raters in this study. The male and female raters varied in age and background. They had completed various amounts of graduate hours, and all had completed a graduate level psychopathology class. Five students, randomly chosen, rated five of the ten case vignettes utilizing the instrument. The remaining five students rated the other five cases.

### Results

Data were subjected to analyzation by the Pearson Product Moment Correlation Coefficient. A profile reliability for classification was determined by correlating the total checkmarks the raters placed in the columns A-I for nine cases (see Table 1). No correlation was obtained for Case 10 (the control case) because only one rater out of the five assessing the case placed any checkmarks in any of the columns. The overall profile reliability was significant at the  $p < .001$  level for cases 1-7 (see Table 1). Case 8 did not have a significant profile reliability and Case 9 was reliable at the  $p < .01$  level.

The checkmarks placed in each column (A-I) were correlated utilizing the Pearson Product Moment Correlation Coefficient to determine individual scale reliability

Table 1  
Profile Reliability for Diagnostic Classification

Scale	Case Classification	r
A (Organic)	1	.95*
B (Substance Abuse)	2	.93*
C (Psychosis)	3	.93*
D (Paranoid)	4	.85*
E (Affective)	5	.89*
I (Personality Disorders)	6	.92*
F (Anxiety)	7	.86*
G (Somatoform)	8	.38
H (Dissociative)	9	.76**

N = 9

\* $p < .001$

\*\* $p < .01$

(see Table 2). Reliability for Scales A, B, F, G, H, and I was significant at the  $p < .001$  level. Scale E was significant at the  $p < .01$  level and C and D were significant at the  $p < .05$  level. The mean, standard deviation, and range were also determined for each scale (see Table 2).

Table 2

Individual Scale (A-I) Reliability and Measures of  
Central Tendency for Diagnostic Classification

Scale	Mean r	Mean	SD	Range
A	.95*	8.32	4.78	4-19
B	.96*	3.08	3.21	0-8
C	.86**	6.96	3.32	2-14
D	.84**	3.24	2.79	0-8
E	.89***	2.40	2.04	0-7
F	.98*	1.04	1.27	0-3
G	.99*	.52	.87	0-2
H	.99*	.20	.41	0-1
I	.99*	.92	1.73	0-5

N = 9

\* $p < .001$

\*\* $p < .05$

\*\*\* $p < .01$

### Discussion

The data strongly support the hypothesis that utilizing the Psychological Rating Scale for Diagnostic Classification for assessing the problematic behaviors, symptoms, or other characteristics of an individual results in a high interrater reliability which would



subsequently lead to higher diagnostic agreement between raters and with DSM-III classification.

These results are significant in that when the interrater reliability is this high, it can be presumed that diagnosis and classification of disorders will be more homogeneous across diagnosticians. High reliability in a classification system will serve to strongly enhance the probability of accuracy in diagnosis. This rating scale assisted the raters in systematically analyzing relevant information about the cases and ruling out nonessential information. It decreased the variability with which the raters generally would have assessed the cases and diminished the chances that rater bias, therapy orientation, sophistication of the rater, etc. would influence their diagnostic decisions.

Item description is specific to symptoms yet appears sufficiently broad to lead directly to diagnostic classification. The item descriptors can apparently provide the information which is essential in developing a symptom syndrome for differential diagnosis.

The highest correlation found in the "field trials" of the DSM-III conducted by Spitzer et al. (1979) was .78 for joint interviews (Axis 1). This interrater correlation dropped to .66 for diagnoses made in separate interviews. The average profile reliability obtained in this study (.85) indicates that a standardized, objective and

structured format such as this rating scale can further increase interrater reliability. It would appear that the process of diagnosis can be more accurately evolved in both form and substance by following the rating scales procedural guidelines which more clearly define the behaviors related to evaluation for specific classification.

The case vignettes obtained from the DSM-III training guide used in this study were relatively short, simple and straightforward. Even so, some degree of rater bias was evident. For example, several raters commented that they "disagreed" with the conclusions and diagnoses derived using the rating scale to assess a case. However, in these cases the raters' subjective diagnoses and interpretations were incorrect, and the diagnoses obtained through use of the rating scale were correct in accordance with the DSM-III training guide. In this instance, use of the rating scale and procedural guidelines which insures the clear ordering of symptoms specifically related to certain diagnoses serves the interest of accuracy in their diagnoses.

The use of case vignettes from the DSM-III training guide provided all raters with identical case material instead of real subjects or patients was preferred to obtain an initial measure of interrater reliability. The use of vignettes may have placed the raters at a

disadvantage, as they could not inquire further regarding certain symptoms and did not actually observe or talk to anyone. It would seem that using real patients may increase the accuracy of the ratings.

The profile reliability for the eighth case (representing Somatoform disorders) was the only one that did not result in significant reliability ( $r = .38$ ). The reason for this lower reliability is not clear, but may have been partially due to a statistical artifact resulting from the limited option choices (checkmarks) placed in the column for the Somatoform case--so that too few numbers may have been insufficient for adequate statistical treatment. It is possible that the disorder needs greater precision in explanation and description. Potential problems with the assessment of this particular disorder should be further investigated. It was noted that when the option choices were "rated," either one (no evidence of the syndrome), two (some evidence of the syndrome), or three (substantial evidence of the syndrome), the interrater reliability measure increased to .89.

This rating scale not only serves to increase interrater reliability, it is simple and convenient to use. It has the advantage of being easy to score, therefore, a trained technician could score the scale, saving the professional considerable time and effort. Another use for the rating scale and procedural

guidelines might be to employ them as training aides for health care professionals. The required systematic direction toward an assessment result should enhance the educational efforts of technical personnel and those professionals in related disciplines.

Although other rating scales and structured interviews have been offered (i.e., Lorr et al. 1963; Overall et al. 1967; Wittenborn, 1951) they are not based on the DSM-III system. Other systems, such as DIAGNO (Spitzer & Endicott, 1968) have been based on the DSM system, but leave out important clinical syndromes such as "Personality Disorders" and "Psychophysical Disorders." The results of the present study supports the Psychological Rating Scale for Diagnostic Classification as a complete, reliable and convenient method to increase interrater reliability when using the DSM-III system. Further studies should be conducted to determine interrater reliability among professionals using regular patients and the reliability determined of their subsequent diagnoses utilizing the scale.

## Appendix A

Case Vignette

A 43-year-old, divorced housepainter is examined in the hospital emergency observation ward. His sister is available to provide some information. The sister indicates that the patient has consumed large quantities of cheap wine, daily, for five years. Evidently, he had a reasonably stable home life and job record until his wife left him for another man five years ago. The sister indicates that the patient drinks more than a fifth a day, and that this has been a pattern since the divorce. He has often had blackouts from drinking, missed work, and consequently has been fired from several jobs. Fortunately, painters are in great demand and he has been able to provide marginally for himself during these years. However, three days ago he ran out of money and has had to beg on the street to buy a meal. He has been very poorly nourished, eating perhaps one meal a day and evidently relying on the wine as his primary source of nourishment.

The morning after his last day of drinking he felt increasingly tremulous, with his hands shaking so grossly that it was difficult for him to light a cigarette. Accompanying this was an increasing sense of inner panic which has made him virtually unable to sleep. A neighbor became concerned about the patient when he seemed not

to be making sense and was clearly unable to take care of himself. The neighbor contacted the sister who brought the patient to the hospital.

On examination, he alternates between apprehension and chatty superficial warmth. He is quite keyed up and talks constantly. At times he recognizes the doctor, but sometimes he thinks that the doctor is the patient's older brother. Twice during the examination the patient called the doctor by his older brother's name and asked when he had arrived, evidently having lost track of the interview up to that point. There is a gross hand tremor at rest and there are periods of picking at bugs he sees on the bedsheets. The patient is disoriented regarding time and thinks that he is in a supermarket parking lot rather than in a hospital. He indicates that he feels he is fighting against a terrifying sense that the world is ending in a holocaust. He is startled every few minutes by sounds and scenes of fiery car crashes (based on the sound of rolling carts in the hall). Efforts at testing memory and calculation fail because his attention shifts too quickly to sustain the effort. An electroencephalogram indicates a pattern of diffuse encephalopathy.

## Appendix B

Case Vignette

A 25-year-old housewife with insomnia obtained a prescription for 10 mg Valium from her family physician, who also prescribed the medication for the patient's mother. The patient found that two pills at bedtime brought satisfying sleep, but she raised the dose to three just to be sure she had enough. Then, she started taking the medicine during the day for relaxation. For about three months, two pills during the day were sufficient, but for the last four months the drug seemed to lose its effectiveness. Consequently, she was taking four and then five pills through the daytime. She had to consume her mother's supply as well as her own, and to pretend that she'd lost a prescription or two in order to secure a sufficient supply. The mother raised objections, but the patient declared that she couldn't cope without the Valium, and that she only craved it more when she tried to cut down. Despite her claim of coping, the patient's husband declared that she was "zonked out" all day and didn't keep up with the housework.

## Appendix C

Case Vignette

A 16-year-old boy moved from a small rural school to a large urban high school for his junior year. Without voicing any lack of confidence about handling this new situation, he became increasingly less communicative over the course of that school year. His grades, which had been all B's and C's, fell to D's and D-'s. Through the following summer, his family noticed that he seemed to have changed, to have become withdrawn into himself. He tended to give laconic responses and sometimes had an inscrutable expression on his face. Two weeks after the senior year began, the boy became so disturbed in the classroom that school authorities contacted his parents, who brought him to the hospital the next week. He appears rather stunned and perplexed, and his tone of voice is flat and mechanical. Occasionally, he controls his face into a grimace and twirls the hair of his right temple between his thumb and fingers. He moves easily about and complies with instructions. He is verbal, but his speech is like "word salad," just an incoherent jumble of words. He seems to try to listen to questions, but his answers are a stream of incoherent speech. He seems at times to be hearing voices or other sounds, in that his eyes dart to the side and he adopts a listening attitude.



## Appendix D

Case Vignette

A beautiful, successful, 34-year-old interior designer is brought to the clinic by her 37-year-old husband, a rather prominent attorney. The husband laments that for the past three years his wife has made increasingly shrill accusations that he is unfaithful to her. He declares that he has done everything in his power to convince her of his innocence, but there is no shaking her conviction. A careful examination of the facts reveals that there is actually no evidence that the man has been unfaithful. When asked what her evidence is, she becomes somewhat vague and mysterious, declaring that she can tell by such things as a faraway look in his eyes.

She is absolutely sure that she is right and considers herself highly insulted to be told that she is imagining the disloyalty. The husband reports that for the last year she has been increasingly bitter, creating a kind of "cold war" atmosphere in the household. Militantly entrenched against the husband and refusing to show him any affection except at social gatherings, she seems intent on giving the impression socially that they have a good relationship. However, after they are alone, the coldness reenters the picture. She has actually physically assaulted the husband on occasion, but her account obscures the fact that she initiated the assault. Her description

of the tussles actually begin with the point where the husband attempted to interrupt her assault by holding her arms. She declares that she will never forgive him for holding her down and squeezing her arms, and her account makes it appear that she was unfairly pinned down by the husband.

The patient experiences no hallucinations; her speech is well organized; she interprets proverbs with no difficulty; she seems to have a good command of current events; and generally she displays no difficulty with thinking, aside from her conviction of the disloyalty. She describes herself as having a generally full and effective life, with a few close friends and no problems except those centering on her experiences of unhappiness in the marriage. The husband reports that his wife is respected for her skills but that she has had difficulties most of her life in close relationships with friends. She has lost a number of friends because she seems always to be intolerant of differences in opinion. The woman reports that she does not want to leave the marriage, nor does she want to have her husband leave her; instead she is furious about the injustice and she demands that it be confessed and redeemed.

## Appendix E

Case Vignette

Harold, a 27-year-old Coca-Cola truck driver, functioned in a routine manner until three weeks ago when his wife suffered a miscarriage. He was found shortly afterward to be in surprisingly and increasingly high spirits--talking loudly and animatedly, clowning around, and cracking jokes that became increasingly crude and coarse. Co-workers, who found this amusing at first, found it exhausting after a while, and they complained that he was racing through his work in a reckless fashion. Warned that his job was in jeopardy, he declared that he didn't need it anymore since he had just invented a new drink that would outsell Coca-Cola and make him a billionaire. A friend from the lab analyzed the drink and found it to be no more than club soda with vanilla flavoring. Undaunted, Harold claimed that this wonder drink would also be a cancer cure that would bring him the Nobel Prize.

Somehow, Harold talked the neighborhood bank into a \$10,000 loan for his venture, but the family soon found that he had given considerable amounts to strangers, whom he referred to as "business associates," after meeting them in bars. He had been spending most of his nights in bars, since he was tireless despite only two or three hours of sleep a night. The family finally persuaded him to come into the hospital.

When the doctor arrived, Harold bounded over and greeted him in a effusive warm manner, as if they were old buddies, and made several grand, cavalier-like gestures in a ceremonial fashion, as if this were a gala occasion. Harold's voice and manner were irrepressively humorous; on hearing the doctor's name, he spun off seven puns in rapid succession associated with the name.

## Appendix F

Case Vignette

Harry is a 40-year-old white male who comes to intake because he is feeling very nervous. During the past month he has been overwhelmed by anxiety on at least eight to ten different occasions. These "fits" come on suddenly and happen at work, at home, and sometimes while he is driving. He gets dizzy, begins to sweat, and becomes very tense. The attacks scare him because he feels he is going to lose all control. He has no history of mental problems and this is the first time he has come to a clinic for help. He has been to his medical doctors but they could not find anything physically wrong. At first, he thought he might be having a heart attack. Harry does not know why these attacks occur and wants to get rid of them.

## Appendix G

Case Vignette

Aretha is a 37-year-old secretary who is currently separated from her husband. Five months ago she discovered that her husband was having an affair and he then asked for a divorce. Six weeks ago she began coughing and having a difficult time breathing. She went to her doctor but he could find nothing wrong. However, she was not convinced of his findings. She believes that she has lung cancer. Her father died of lung cancer five years ago and Aretha has smoked cigarettes since she was 14. She is also losing weight, which she feels confirms her belief. She has gone to cancer specialists and had x-rays which were negative. However, no one has been able to explain her persistent coughing and she remains convinced that she has lung cancer. Recently she lost her job because she has taken off so many sick days for doctor's visits and because she stays home in bed.

## Appendix H

Case Vignette

Burt Tate is a 42-year-old white male. He was brought to the emergency room by the police. He had been in a fight in the diner where he worked. When the police began to question him, they discovered that he had no identification, that he had drifted into town last week and begun working as a short-order cook at the diner. He did not know where he had come from before this time and could not recall any details of his past life. When the police ran a description check on him, they found that he fit the description of Gene Smith, a missing person who disappeared one month ago from a town 200 miles away. A physical exam did not uncover any head trauma and there was no evidence of drug abuse. A visit by his wife confirmed the real identity of the man as Gene Smith. His wife explained that he had been having a lot of problems with his job and had been under a considerable amount of stress. There was no history of any previous psychiatric disorder or serious medical problem.

## Appendix I

Case Vignette

Susan is a 26-year-old teacher's aide who came to the center for counseling. For six months she has been feeling increasingly lonely and "lost" since her sister who is two years older, was married and moved out of town. This sister had been Susan's only real social contact; otherwise she had no girlfriends to speak of and was extremely afraid of men. Because she felt that she had very little to offer, she always anticipated that men, even if attracted, would quickly find fault with her and she would be "dropped." Although she wanted to get married, she never dated a man beyond three dates. This was her first attempt to get professional help.



## Appendix J

Case Vignette

Martha is a 25-year-old student. She is attending school part-time and is a homemaker. Her husband is a CPA. They have been married three years and have no children. Martha came to the center for career counseling. She is not sure of what her interests or vocational strengths are. She has never been to the center before for any reason, but her sister has received counseling there for the past year.









	A	B	C	D	E	F	G	H	I
<u>PERCEPTUAL INVOLVEMENT:</u>									
27. Evidence or reports of hallucinatory experiences (i.e., he or she sees, hears, feels, etc., things which are not really present).			2						
28. Delusions - unreasonable or exaggerated beliefs and ideas that have little or no basis in fact, but do follow a coherent theme.			2	2					
29. Experiences fragmentary delusions or hallucinations that do not follow a coherent theme.			2						
30. Experiences unusual perceptions, such as recurrent illusions, sensing the presence of a force or person not actually present.									
31. Bizarre ideation present, or magical thinking (e.g., superstitiousness, clairvoyance, telepathy, "sixth sense", etc.).									
32. Delusions related to "thought broadcasting" (others can hear thoughts), thoughts are "inserted" into head by others, actions are "controlled" by others, etc.			3						
33. Grandiose delusions and ideations, such as inflated self worth; belief that one possesses special power, knowledge, identity, or special relationship to deity or famous person.			2						















## Appendix L

Psychological Rating Scale for Diagnostic Classification  
to be used with DSM-III

Instructions

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

Appendix M

SUMMARY PAGE

A X I S I  
 C L I N I C A L S Y N D R O M E  
 A X I S II  
 PERSONALITY DISORDER

Organic Disorders  
 Substance Abuse  
 Psychosis  
 Paranoid  
 Affective  
 Anxiety  
 Somatoform  
 Dissociative

A B C D E F G H I

Some Evidence 5+ 3+ 5+ 3+ 4+ 2+ 0 0 2+

Substantial Evidence 7+ 4+ 10+ 4+ 6+ 3+ 1+ 1+ 3+

Axis III: Presence of Medical History with possible related symptoms with definite supportive medical findings

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

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

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

## Appendix N

Psychological Rating Scale for Diagnostic Classification  
Procedural Guidelines for CodingSUBSTANCE USE DISORDERS

- A. Substance Abuse: #36, #37, and #38  
Name substance: alcohol, barbituates, or similarly acting sedatives or hypnotics, opioids, amphetamines or similarly acting sympathomimetics, cannabis.
- B. Substance Dependence: #39 Tolerance (Markedly increased amounts of the substance are required for the desired effect.)  
Use same substance as listed above.
- Course (5th digit)
- 1 Continuous (more than 6 months)
  - 2 Episodic (circumscribed period of maladaptive use)
  - 3 In remission (previous maladaptive use)
  - 0 Unspecified (course unknown)
1. ALCOHOL ABUSE: Meets criteria of Substance Abuse  
305.0X -- duration of at least 1 month  
-- pathological alcohol use causing maladaptive behaviors such as #17, #44, #5, etc.
  2. BARBITUATE OR SIMILARLY ACTING SEDATIVES OR HYPNOTICS ABUSE:  
305.4x -- meets criteria of Substance Abuse  
-- pathological use causing maladaptive behaviors such as #17, #44, #5, etc.  
-- duration at least 1 month
  3. BARBITUATE (OR SIMILAR DRUG) DEPENDENCE:  
304.1x -- meets Substance Dependence criteria

4. OPIOID ABUSE: Meets criteria for Substance Abuse  
305.5x -- duration at least 1 month  
-- pathological use causing maladaptive behavior such as #17, #44, #5, etc.
5. OPIOID DEPENDENCE:  
304.0x Meets criteria for Substance Dependence
6. COCAINE ABUSE: Meets criteria for Substance Abuse  
305.6x -- duration of at least 1 month  
-- pathological use causing maladaptive behavior
7. AMPHETAMINE OR SIMILARLY ACTING SYMPATHOMIMETICS ABUSE:  
305.7x Meets criteria for Substance Abuse  
-- at least 1 month duration
8. AMPHETAMINE (OR SIMILAR DRUG) DEPENDENCE:  
304.4x Meets criteria for Substance Dependence
9. PCP ABUSE: Meets criteria for Substance Abuse  
305.9x -- duration at least 1 month
10. HALLUCINOGEN ABUSE:  
305.3x Meets criteria for Substance Abuse  
-- duration at least 1 month
11. CANNABIS ABUSE:  
305.2x Meets criteria for Substance Abuse  
-- duration at least 1 month
12. CANNABIS DEPENDENCE:  
304.3x Meets criteria for Substance Dependence
13. TOBACCO DEPENDENCE:  
305.1x Meets criteria for Substance Dependence  
-- duration at least 1 month  
-- at least 1 unsuccessful attempt to quit, withdrawal symptoms, individual uses tobacco despite serious physical disorder
14. OTHER, MIXED (MORE THAN 1) OR UNSPECIFIED (UNKNOWN) SUBSTANCE ABUSE:  
305.9x Meets criteria for Substance Abuse  
-- substance such as glue
15. OTHER SPECIFIED SUBSTANCE DEPENDENCE:  
304.6x e.g., codeine



16. UNSPECIFIED  
304.9x
17. COMBINATION OF OPIOID AND OTHER NONALCOHOLIC SUBSTANCE  
304.7x
18. COMBINATION OF SUBSTANCES EXCLUDING OPIOID AND ALCOHOL  
304.8x

PSYCHOSIS

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

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

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

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

TYPES OF SCHIZOPHRENIA:

- 255.1x DISORGANIZED (HEBEPHRENIC): Predominant features: #29, #64, #40 or 41
- 295.2x CATATONIC: Predominant feature: #52
- 295.3x PARANOID: Predominant features: #27 or 28 with #4, #33
- 295.9x UNDIFFERENTIATED: Not any of the above listed types or meets criteria for more than one
- 295.6x RESIDUAL: -history of at least one previous episode of Schizophrenia with prominent psychotic symptoms, (i.e., #27, #28, #26)  
-or admission to clinical care  
-continuing evidence of illness (i.e., #1, #40, #26, #16)

COURSE (5th digit)

- 1 Subchronic: signs of illness less than 2 years, at least 6 months
  - 2 Chronic: symptoms more than 2 years
  - 3 Subchronic with acute exacerbation: reemergence of psychotic symptoms in individual with subchronic course who has been in residual phase
  - 4 Chronic with acute exacerbation: reemergence of psychotic symptoms in individual with chronic course who has been in residual phase
  - 5 In remission: history of schizophrenia, free of all signs of illness (whether or not on medication)
- B. 295.40 SCHIZOPHRENIFORM: Meets all criteria for schizophrenia, except duration of more than 2 weeks, less than 6 months.
- C. 298.80 BRIEF, REACTIVE PSYCHOSIS: At least 1 psychotic symptom (i.e., #27, #28, #26, #52) apparently caused by a recognizable and legitimate psycho-social stressor. Symptoms last more than a few hours, but less than 2 weeks, with return to premorbid functioning.
- D. 295.70 SCHIZOAFFECTIVE DISORDER: Unable to make differential diagnosis with any degree of certainty between Affective Disorder or Schizophreniform or Schizophrenia.
- E. 298.90 ATYPICAL PSYCHOSIS: Psychotic symptoms (i.e., #26, #27, #28) that do not meet criteria for any specific mental disorder.

PARANOID DISORDER

- PARANOID DISORDER: Predominant feature #28 with content of #4 or #5  
 -- duration of at least 1 week  
 -- NOT Schizophrenia or Affective or Organic  
 -- NO #27
- 297.10 PARANOIA: Same as above, at least 6 months duration  
 -- NOT Shared Paranoid (See below)

297.30 SHARED PARANOID DISORDER:

Meets Paranoid Disorder criteria

- Delusions develop as a result of a close relationship with another person or persons who have persecutory delusions.

298.30 ACUTE PARANOID DISORDER:

Meets Paranoid Disorder criteria

- Less than 6 months duration
- NOT Shared Paranoid Disorder (see above)

297.90 ATYPICAL PARANOID DISORDER:

Meets Paranoid Disorder criteria, but none of the above specific disorders

AFFECTIVE DISORDERS

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

5th Digit Code Number's

6 = In Remission - previous mania, now free from symptoms

4 = With psychotic features-#27, #28, #26 and #16 also predominant

2 = Without psychosis

0 = Unspecified

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

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

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

5th Digit Code Number's

- 6 = In remission - previous depression, now free from symptoms
- 4 = With psychotic features (e.g., #27 or #28)
- 0 = Unspecified
- 3 = With melancholia - #42 with 3 of the following:  
 1) distinct quality of depressed mood, i.e., depressed mood is perceived as different from kind experienced after death of loved one; 2) depression worse in morning; 3) early morning awakening at least 2 hours before usual time; 4) #60 or #48; 5) #58 (weight loss); 6) #70
- C. BIPOLAR, MIXED: Both Manic and Depressive episodes, intermixed or rapidly alternated -- depression prominent and lasts at least 1 day -- use mania 5th digit codes.  
296.6x
- D. BIPOLAR, MANIC: Most recently in a manic episode (does not have to meet full criteria for mania)  
296.4x
- E. BIPOLAR, DEPRESSED: Has had one or more manic episodes, but currently in a major depressive episode (does not have to meet full criteria for depression)  
296.5x
- F. MAJOR DEPRESSION, SINGLE EPISODE: Depressive episode, NEVER had a manic episode.  
296.2x
- G. MAJOR DEPRESSION, RECURRENT: More than one depressive episode, NEVER a manic episode  
296.3x
- H. CYCLOTHYMIC DISORDER: Both depression and mania, but neither severe enough to be exclusively either -- may be periods of normal mood that may last months.  
-- NO psychosis (#26, #27, #28) or other mental disorder.  
301.13
- I. DYSTHYMIC DISORDER: Depression (#45, #42, etc.) over a 2 year period not severe enough to be considered major depression. May have periods of normal mood for days or weeks (not more than a few months).  
-- NO psychosis (#26, #27, #28).  
300.40

- J. ATYPICAL BIPOLAR: Manic features, cannot be classified as bipolar or cyclothymic.  
296.70
- K. ATYPICAL DEPRESSION: Depressive symptoms cannot be classified as having major or other affective disorder.  
296.82

ANXIETY DISORDERS

- A. PHOBIC DISORDERS (PHOBIC NEUROSIS)
1. 300.22 AGORAPHOBIA: #65, specifically avoids being alone or in places from which escape might be difficult or help not available in cases of sudden incapacitation, e.g., crowds, tunnels, bridges, etc.  
-- NOT due to any other disorder  
  
300.21 AGORAPHOBIA WITH PANIC ATTACKS (See below description of Panic Attacks)
  2. 300.23 SOCIAL PHOBIA: #65 and #1, person fears that he or she will act in a way that would be humiliating or embarrassing, e.g., performing or eating in public.  
-- NOT due to any other disorder
  3. 300.29 SIMPLE PHOBIA: #65, all other fears besides Social or Agoraphobia, e.g., animals, heights, closed spaces.
  4. 300.01 PANIC DISORDERS: 3 panic attacks within a 3 week period (except in a life threatening situation or physical exertion). Symptoms of 4 or more: sweating, faintness, trembling, chest pain, palpitation, dizziness, tingling in hands, hot or cold flashes, dyspnea, feelings of unreality.  
-- NOT due to another disorder.
- C. 300.12 GENERALIZED ANXIETY DISORDER: At least 3 of the 4 categories listed in #66.  
-- NOT due to another mental disorder  
-- at least 18 years old
- D. 300.30 OBSESSIVE-COMPULSIVE DISORDER: #67 or #68  
-- NOT due to another mental disorder
- E. POST TRAUMATIC STRESS DISORDER: Predominant symptom #69  
Any 1 of the following: #1, #40, #42  
Any 2 of the following: #49 or 50, #20, #70,  
Hyperalertness or startle response, avoidance of activities that remind individual of trauma,

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

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

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

SOMATOFORM DISORDERS AND PSYCHOLOGICAL FACTORS AFFECTING PHYSICAL CONDITION

- 300.81 SOMATIZATION DISORDER: Predominant feature #53  
 -- history of physical symptoms of several years duration beginning before age 30
- 300.11 CONVERSION DISORDER: Predominant feature #56  
 -- NOT due to Somatization or Schizophrenia  
 -- NOT just pain or sexual dysfunction  
 -- judged to be NOT under voluntary control
- 307.80 PSYCHOGENIC PAIN DISORDER: #56 with pain as symptom  
 -- Pain symptom is either inconsistent with anatomic distribution or cannot be accounted for by organic pathology after examination.  
 -- NOT due to another mental disorder
- 300.70 HYPOCHONDRIASIS (HYPOCHONDRIACAL NEUROSIS): #55 which causes impairment in social or occupational functioning.  
 -- NOT due to another mental disorder
- 300.70 ATYPICAL SOMATOFORM DISORDER: #56 or #53 without all 12-14 symptoms  
 -- physical symptoms or complaints that do not meet any listed criteria for somatoform disorder (e.g., preoccupation with defect in physical appearance)
- 316.00 PSYCHOLOGICAL FACTORS AFFECTING PHYSICAL CONDITION: #54 (e.g., obesity, tension headache, migraine, angina pectoris, painful menstruation, arrhythmia, gastric ulcer, asthma, rheumatoid arthritis, neurodermatitis, colitis, nausea, etc.)

NOTE: List all appropriate physical conditions of AXIS III

DISSOCIATIVE DISORDERS

- 300.12 PSYCHOGENIC AMNESIA: Predominant feature #21.  
-- NOT due to Organic Mental Disorder
- 300.12 PSYCHOGENIC FUGUE: Predominant feature #21, with sudden, unexpected travel away from one's home or customary place of work--may assume new identity.  
-- NOT due to Organic Mental Disorder
- 300.14 MULTIPLE PERSONALITY: Predominant feature #18, each individual personality is complex and integrated with its own unique behavior patterns and social relationships.
- 300.60 DEPERSONALIZATION DISORDER: #35  
-- NOT due to any other mental disorder  
-- NOTE: Mild depersonalization normally occurs at some time in 30-70% of young adults.

PERSONALITY DISORDERS (AXIS II)

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

- A. PARANOID: Predominant symptoms: #4, #5, and #6 or #10  
301.00 NOT due to a psychotic disorder
- B. 301.20 SCHIZOID PERSONALITY: Predominant symptoms:  
#6 with #10, #1  
-- NOT due to psychosis
- C. 301.22 SCHIZOTYPAL PERSONALITY: At least 4 of the following: 1) #30 2) #31 3) #12 4) #1 5) #61  
6) #10 or 6 7) #5 8) #4  
-- NOT Schizophrenia
- D. 301.50 HISTRIONIC (HYSTERICAL): #11, 2 of the following:  
1) #11 2) #12 3) #15 4) #46 5) #6
- E. 301.81 NARCISSISTIC: Predominant symptom: #12, cool indifference or feelings of rage, inferiority, shame, humiliation or emptiness in response to criticism, indifference of others, or defeat

- F. 301.70 ANTISOCIAL: Predominant symptom: #7  
 -- at least 18 years old  
 -- at least 4 antisocial manifestations, such as:  
 inability to sustain current work, irresponsible  
 parent aggressiveness, failure to honor financial  
 obligations, repeated lying, etc.  
 -- pattern of continuous violation of rights of  
 others since age 15 (except if in hospital or  
 institution)
- G. 301.85 BORDERLINE: Predominant symptom: #19
- H. 301.82 AVOIDANT: Predominant symptom: #13
- I. 301.60 DEPENDENT: Predominant symptom: #15
- J. 301.40 COMPULSIVE: Predominant symptom: #14
- K. 301.84 PASSIVE-AGGRESSIVE: Predominant symptom: #9

ORGANIC

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

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

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

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

292.00 Barbituate or Similarly Acting Sedative or  
 Hypnotic Withdrawal Delirium  
 - delirium occurring within one week after  
 cessation of or reduction in heavy use of a  
 barbituate or similarly acting sedative.  
 - autonomic hyperactivity



292.81 Amphetamine or Similarly Acting Sympathomimetic  
Delirium  
- delirium within 24 hours as a result of use of  
amphetamine or similarly acting sympathomimetic

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

292.81 Other or Unspecified Substance Delirium

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

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

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

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

Subtypes

Senile Onset (after 65)

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

Presenile Onset (age 65 or below)

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

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

291.2x Dementia associated with Alcoholism (severity)

- dementia following prolonged, heavy ingestion of alcohol
- Dementia persists at least three weeks after cessation of alcohol ingestion.

Severity Criteria

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

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

- 294.00 With pathophysiological
- 291.10 Alcohol Amnestic Disorder
- amnestic syndrome due to prolonged heavy ingestion of alcohol
- 292.83 Barbituate or Similarly Acting Sedative or Hypnotic Amnestic Disorder
- amnestic syndrome due to prolonged, heavy use of a barbituate or similarly acting sedative or hypnotic
- 292.83 Other or Unspecified Substance Amnestic Disorder

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

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

293.81 With pathophysiological

292.11 Amphetamine or Similarly Acting

Sympathomimetic Delusional Disorder

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

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

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

292.11 Hallucinogen Delusional Disorder due to recent hallucinogen use.

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

292.11 Cannabis Delusional Disorder

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

292.11 Other or Unspecified Substance Delusional Disorder

Organic Hallucinosis: Predominant feature: #27, #57 or #36; NOT prominent: #25, #23, #28 (Affective Disorder).

293.82 With pathophysiological

291.30 Alcohol hallucinosis

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

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

- Maladaptive behavioral effects, i.e., #4, #66, #3

## 292.12 Other or Unspecified Substance Hallucinosiis

Organic Affective Syndrome - #57 or #36

At least 2 of the following:

- Depression - #60, #2, #62, #33, #50, #25
- Manic - #58, #49, #50, #60, #48, #70,  
#42, #15, #46

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

## 293.83 Organic Affective Syndrome - pathophysiological

## 292.84 Hallucinogen Affective Disorder

- recent use of hallucinogen causing OAS that persists beyond 24 hours after cessation of hallucinogen use

Organic Personality Syndrome: #57 or #36

- marked change in behavior or personality involving at least one of the following:

1. #43
2. #3
3. #42
4. NO #25, #23, #27, #28

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

## 303.11 Alcohol Intoxication

- recent ingestion of alcohol that causes maladaptive behavior such as #3, #5, #44, etc.
- corresponding physiological significance such as slurred speech, unsteady gait, etc.

## 310.10 with pathophysiological

## 291.40 Alcohol Idiosyncratic Intoxication

- marked behavioral change, i.e., #5 that is due to the recent ingestion of an amount of alcohol insufficient to induce intoxication in most people
- The behavior is atypical of the person when not drinking.

## 292.84 Other or Unspecified Substance Personality Disorder

## 305.40 Barbituate or Similarly Acting Sedative or Hypnotic Intoxication

- recent use of barbituate causing maladaptive behavior such as #3, #44, #17.
- Neurological signs such as slurred speech, unsteady gait, etc.

## 305.50 Opioid Intoxication

- recent use of opioid causing maladaptive behavior such as #3, #44, #17
- pupillary constriction or dilation
- Psychological signs such as euphoria, psychomotor retardation.
- Neurological signs drowsiness, slurred speech, impairment in attention or memory.

## 305.60 Cocaine Intoxication

- recent use of cocaine causing maladaptive behavior such as #3, #44, #17.
- at least two physical symptoms within one hour of using cocaine, such as tachycardia, perspiration or chills, elevated blood pressure.

## 305.70 Amphetamine or Similarly Acting Sympathomimetic Intoxication

- recent use of amphetamine causing maladaptive behavior such as #3, #44, #17.
- within one hour of use, at least two physical symptoms such as tachycardia, elevated blood pressure, perspiration or chills.

## 305.90 PCP or Similarly Acting Arylcyclohexylamine Intoxication

- recent use causing maladaptive behaviors such as #3, #44, #17.

## 305.20 Cannabis Intoxication

- recent use of cannabis causing #4, #5, #44, #17
- tachycardia and other physical symptoms such as increased appetite, dry mouth

## 305.90 Caffeine Intoxication

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

Withdrawal - #39

## 291.80 Alcohol Withdrawal

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

## 292.00 Barbituate Withdrawal

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

## 292.00 Opioid Withdrawal

- prolonged, heavy use
- at least 4 symptoms such as lacrimation, rhinorrhea, pupillary dilation, piloerection, diarrhea, fever.

## 292.00 Amphetamine Withdrawal

## 292.00 Tobacco Withdrawal

294.80 Atypical or Mixed Organic Behavioral Syndrome  
#57 - does not meet any criteria listed.292.90 Other or Unspecified Substance Atypical or Mixed  
Organic Mental Disorder

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