Eur Arch Psychiatry Clin Neurosci (1993) 242:218–223

European Archives of Psychiatry and Clinical Neuroscience

Routine Psychiatric Examinations Guided by ICD-10 Diagnostic Checklists (International Diagnostic Checklists)

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Received December 4, 1992

Summary. A systematic assessment of psychiatric diagnoses according to the new classification system ICD-10 can be guided and enhanced by the International Diagnostic Checklists (IDCL). This instrument was developed and evaluated primarily for use in routine clinical care. It consists of 30 separate lists in pocket form, each assigned to a specific disorder and allowing immediate and operationalized diagnostic decisions (without the need of computer assistance). Personality disorders are covered by a separate 12-page booklet (IDCL-P). Examples of the checklists are given together with possible areas of application. First studies have indicated good clinical practicability and satisfactory to excellent diagnostic reliability.

Key words: Classification – ICD-10 – International Diagnostic Checklists (IDCL)

Introduction

The new tenth International Classification of Diseases (ICD-10), developed and introduced by the World Health Organization (WHO), defines psychiatric disorders more precisely than traditional classifications. Diagnoses are based on descriptive features such as signs and symptoms, time of onset, course and the degree of severity (Cooper 1988; Dittmann and Dilling 1990; Maier et al. 1990). ICD-10 also provides diagnostic criteria for research which specify diagnostic decision rules (algorithms) for an operationalized assessment of diagnoses (WHO 1990).

The criteria-related approach of ICD-10 has important implications for the diagnostic process in clinical and scientific work (Burke 1988; Mombour et al. 1990). Above all, the evaluation of a patient's psychopathology has to be systematic and more standardized. The diagnostician must refer to explicit criteria in order to ascertain that all information needed for his diagnostic decision is available.

New methods of assessing psychiatric findings are therefore increasingly important, including the use of diagnostic instruments. They can assist the diagnostician by providing a criteria catalogue which can be used as a guideline during the examination of a patient (since clinicians can usually not be expected to keep the numerous diagnostic criteria in memory). Furthermore, clear and easily usable instructions should be available for deciding whether the criteria of a specific diagnosis are fulfilled or not.

Until now, a large number of interview methods have been developed for the assessment of criteria and diagnoses (e.g. Wing et al. 1974, 1990; Endicott and Spitzer 1978; Robins et al. 1981, 1988; Philipp and Maier, 1986; Spitzer et al. 1987). Most of them are designed for diagnostics according to the DSM-III/DSM-III-R system of the American Psychiatric Association (1987). All interviews imply a structured and standardized diagnostic process and have proved to be sufficiently reliable (e.g. Spitzer et al. 1978; Burnam et al. 1983; DiNardo et al. 1983; Semler et al. 1987; Robins et al. 1988).

However, interview techniques do not seem to be free of disadvantages. Under clinical routine conditions, highly structured procedures tend to be too lengthy (with frequently more than one hour for a single examination) and somehow cumbersome in application (since a fixed order of sequence is required together with pre-formulated questions, allowing only little flexibility). Furthermore, interviews can often not be carried out on patients presenting with severe acute symptomatology (e.g. states of disorientation, delirium, catatonic states, intoxication, mutism) or with patients suffering from severe organic mental disorders (e.g. dementia and associated

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impairment of memory). Reliable verbal exploration is often impossible with uncommunicative patients, malingerers and with patients in acute crises. This necessitates gathering information from other sources.

As a clinical alternative to interviews, we have developed the International Diagnostic Checklists (IDCL) to serve as a guideline for diagnostics according to ICD-10 (Hiller et al. 1993). This instrument, originally introduced under the label "MDCL" (Munich Diagnostic Checklists), allows to examine patients in a systematic way by directly referring to the descriptions and definitions of ICD-10. The IDCL for ICD-10 are associated to the family of instruments provided by the WHO for assessment according to this new classification. An equivalent but independent version of the instrument also exists for DSM-III-R (Hiller et al. 1990a).

A major stimulation for the IDCL has come from the historical importance of checklists in psychiatry, especially from rating scales for psychopathological symptoms and syndromes (e.g. Wittenborn 1955; Lorr et al. 1963). Our work was further influenced by the specific clinical demands of psychiatric outpatient diagnostics in the Max-Planck-Institute of Psychiatry in Munich (FRG) where 15 to 20 patients were to be examined and treated daily in routine examinations of usually 30 to 60 minutes.

In the following sections, we will describe the concept and design of the IDCL for ICD-10. Examples of diagnostic criteria as incorporated into the checklists will be given. It will be illustrated how the IDCL can be used for individual diagnostic decisions and major areas of application will be outlined.

Description of the IDCL

The IDCL for ICD-10 represent a homogeneously designed instrument, consisting of 30 separate pocket-sized lists for clinical syndromes and a small 12-page booklet for personality disorders. They cover the most important and common psychiatric diagnoses. Each checklist is assigned to one single disorder. All relevant diagnostic criteria are listed and coding-boxes are provided for rating their presence or absence. The criteria are represented by letters or numbers corresponding to their entry in the classification system. Clear decision rules are given for the clinician to determine whether the diagnostic criteria for a specific disorder are fulfilled or not. Each checklist can be used to accept or reject a diagnosis (i.e. to "test" a diagnostic hypothesis) during or immediately after exploration and clinical examination.

For the spectrum of clinical syndromes, the IDCL for ICD-10 consist of the following checklists (subclassified by the different sections of ICD-10):

- *Affective disorders (F3):* Depressive episode (F32 and F33), Manic episode or Hypomania (F30 and F31), Dysthymia (F34.1), Cyclothymia (F34.0), Adjustment disorder (F43.2).
- *Anxiety disorders (F4):* Panic disorder (F41.0), Agoraphobia (F40.0), Social phobias (F40.1), Specific (isolated) phobias (F40.2), Generalized anxiety disorder (F41.1), Obsessive-compulsive disorder (F42).
- *Schizophrenia and related psychotic disorders (F2):* Schizophrenia (F20), Simple schizophrenia (F20.6), Acute and transient psychotic disorders (F23), Schizoaffective disorder (F25), Delusional disorder (F22), Schizotypal disorder (F21).
- *Organic mental disorders (F0 and parts of F1):* Delirium (F05 and F1x.4), Withdrawal state (F1x.3), Acute intoxication (F1x.0), Organic amnestic syndrome (F04 and F1x.6), Organic mental disorders (F06), Organic personality and behavioral disorders (F07), Psychotic disorder induced by drugs or alcohol (Flx.5), Residual and late onset psychotic disorder induced by drugs or alcohol (F1x.7).
- *Other non-organic and non-psychotic disorders:* Alcohol dependence and harmful use (F10.2 and F10.1), Drug dependence and harmful use (F1x.2 and F1x.1), Anorexia nervosa (F50.0), Bulimia nervosa (F50.2), Somatization disorder (F45.0).

All lists encompass two to four pages. Two-page lists consist of one single sheet (printed on the front and the back), three- or four-page lists are folded once. To increase the practicability of the instrument, different colors were chosen for each of the disorder sections and the individual lists can easily be recognized by color shades within each section.

The typical IDCL design is illustrated in Fig. 1 with the front pages of the IDCL "Schizophrenia", "Depressive episode", "Panic disorder", and "Delirium". The clinician can check each criterion with "No", "Yes", or "Probably" (whenever a criterion cannot be assessed definitely, but is judged to be present with some degree of confidence). For example, if schizophrenia is thought to be a possible diagnosis for a patient being examined, the list can be used to systematically screen for all relevant symptoms. The diagnostician is then able to decide if criterion A of schizophrenia is or was fulfilled (i.e., by checking if at least one symptom from *1a* to *1d*, or at least two symptoms from *2e* to *2h* were coded "Yes" or "Probably"). It can be documented in all lists whether a current or previous symptomatology has been assessed. Thus, lifetime diagnoses can be determined.

Figure 2 illustrates how diagnostic decision rules are included into the IDCL. For the diagnosis of a depressive disorder according to ICD-10, the clinician must first decide whether a depressive episode is part of a recurrent depressive disorder or not. This enables him to fill in the appropriate third character of the diagnosis (the first two characters are always "F3"). In consecutive steps, he can specify the severity of current state (leading to the fourth character of the diagnostic code), and presence/absence of a somatic syndrome (fifth character). Fig. 2 shows in which way IDCL-guided diagnoses can be done by hand (i.e. without computer assistance).

The IDCL-P is a separate 12-page booklet for the assessment of personality disorders (Bronisch et al. 1992). The first two pages contain the six general criteria which apply to *all* personality disorders in chapter F6 of

IDCL *International Diagnostic Checklist for ICD-10*

Schizophrenia

Name: _____

Age: ____ Date: _____

A

- Define the pattern of psychotic symptomatology
- Minimum duration for all symptoms: *one month*, for *most of the time* during an episode of psychotic illness

		No	Probably	Yes
(1)	***a*** *Thought echo*, thought *insertion* or *withdrawal*, and thought *broadcasting*	☐	☐	☐
	b *Delusions of control*, *influence* or *passivity*, clearly referred to body or limb movements or specific thoughts, actions, or sensations, and *delusional perception*	☐	☐	☐
	c *Hallucinatory voices*, ♦ giving a running commentary on the patient's behavior, ♦ or discussing him between themselves, ♦ or with other types of hallucinatory voices coming from some part of the body	☐	☐	☐
	d Persistent *delusions of other kinds* that are culturally inappropriate or implausible e.g., religious or political identity, superhuman powers and ability	☐	☐	☐
(2)	***e*** Persistent *hallucinations in any modality*, ♦ accompanied by either fleeting or half-formed delusions without clear affective content, ♦ or accompanied by persistent over-valued ideas, ♦ or when occuring every day for weeks or months on end	☐	☐	☐
	f Breaks or interpolation in the *train of thought*, resulting in incoherence or irrelevant speech, or neologisms	☐	☐	☐
	g *Catatonic behavior* e.g., excitement, posturing, negativism, mutism, stupor	☐	☐	☐
	h *"Negative" symptoms*, not due to depression or to neuroleptic medication e.g., marked apathy, paucity of speech, blunting or incongruity of emotional responses	☐	☐	☐

Criterion A is fulfilled
- if at least 1 item from ***1a*** to ***1d*** is met
- or if at least 2 items from ***2e*** to ***2h*** are met

No ☐ | Probably ☐ | Yes ☐

Stop ←

IDCL *International Diagnostic Checklist for ICD-10*

Depressive episode

Name: _____

Age: ____ Date: _____

(1) *Depressed mood* to a degree that is definitely *abnormal* for the subject, present for most of the day and almost every day, largely uninfluenced by circumstances, and sustained for at least *two weeks*

No ☐ | Probably ☐ | Yes ☐

- Define the pattern of depressive symptomatology
- Relate *all symptoms* to the period coded in (1)

		No	Probably	Yes
(2)	Marked loss of *interest* or *pleasure* in activities which are normally pleasurable	☐	☐	☐
(3)	Decreased *energy* or increased *fatiguability*	☐	☐	☐
(4)	Loss of *confidence*, and *self-esteem*	☐	☐	☐
(5)	Unreasonable feelings of *self-reproach* or excessive and inappropriate *guilt*	☐	☐	☐
(6)	Recurrent thoughts of *death* or *suicide*, or any *suicidal behaviour*	☐	☐	☐
(7)	Complaints or evidence of diminished ability to *think* or *concentrate*, such as *indecisiveness* or *vacillation*	☐	☐	☐
(8)	Change in *psychomotor activity*, with agitation or retardation	☐	☐	☐
(9)	*Sleep* disturbance of any type	☐	☐	☐
(10)	Change in *appetite* (decrease or increase) with corresponding *weight change*	☐	☐	☐

Specify if symptomatology is current or previous:

☐ Yes ☐ Probable	☐ Yes ☐ Probable	☐ Yes ☐ Probable
Current: Symptomatology exists currently for the first time.	**Current and previous:** Symptomatology exists currently, and it had also been present in past history.	**Previous:** Symptomatology existed in past history (specify: _____)

IDCL *International Diagnostic Checklist for ICD-10*

Panic disorder

Name: _____

Age: ____ Date: _____

A Recurrent *panic attacks*,
- ♦ that are *not* consistently associated with a specific situation or object,
- ♦ *and* that often occur *spontaneously* (i.e. the episodes are unpredictable)

No ☐ Probably ☐ Yes ☐

↓ Stop

Note: The panic attacks must not be associated with marked exertion or with exposure to dangerous or life-threatening situations

B Specify which symptoms develop during a panic attack

		No	Probably	Yes
(1)	*Palpitations* or *pounding heart* (not merely occasional extra-systoles)	☐	☐	☐
(2)	Hot or cold *sweats* or *flushes*	☐	☐	☐
(3)	*Trembling* or shaking of limbs	☐	☐	☐
(4)	*Dry mouth* (not due to medication or dehydration)	☐	☐	☐
(5)	Feeling of *loss of emotional control* or *going mad* or *impending death*	☐	☐	☐
(6)	*Discomfort* or *pains* in chest or epigastrium (e.g. "butterflies" or churning in the stomach)	☐	☐	☐
(7)	Difficulty in *breathing* or feelings of choking	☐	☐	☐
(8)	Feelings of *dizziness*, *unsteadiness* or *light-headedness*	☐	☐	☐
(9)	Feelings of *unreality*, being *distant*, *"not really here"*	☐	☐	☐

Criterion B is fulfilled under the following conditions:
- ♦ A panic attack must be a *discrete episode* of fear and other symptoms, which starts *abruptly*, soon reaches a *crescendo*, and lasts at least *some minutes*
- ♦ Presence of at least two symptoms from (1) to (9) on at least one occasion, *one of which* must be from symptoms (1) to (4)

Decide if criterion B is met: No ☐ Probably ☐ Yes ☐ Stop ←

IDCL *International Diagnostic Checklist for ICD-10*

Delirium

Name: _____

Age: ____ Date: _____

A Impairment of *consciousness* and *attention*, which may vary in severity (e.g., reduced awareness, orientation and perception, reduced ability to direct, focus, sustain, or shift attention)

No ☐ Probably ☐ Yes ☐

↓ Stop

B Define symptoms of global disturbance of cognition

		No	Probably	Yes
(1)	*Disturbances of perception* (including illusions and hallucinations)	☐	☐	☐
(2)	Impairment of *abstract thinking* and *comprehension* (with or without transient delusions, but typically with some degree of incoherence)	☐	☐	☐
(3)	Impairment of *immediate recall* and *recent memory*, with relatively intact remote memory	☐	☐	☐
(4)	*Disorientation in time* (in more severe cases, also for place and person)	☐	☐	☐

At least 3 items from (1) to (4) — No ☐ Probably ☐ Yes ☐ Stop ←

C Define symptoms of psychomotor disturbances

		No	Probably	Yes
(1)	Rapid, unpredictable shifts from *hypo-activity* to *hyper-activity*	☐	☐	☐
(2)	Increased *reaction time*	☐	☐	☐
(3)	Increased or decreased *flow of speech*	☐	☐	☐
(4)	Enhanced *startle reaction*	☐	☐	☐

At least 1 item from (1) to (4) — No ☐ Probably ☐ Yes ☐ Stop ←

Fig. 1. Front pages of the IDCL "Schizophrenia", "Depressive episode", "Panic disorder", and "Delirium"

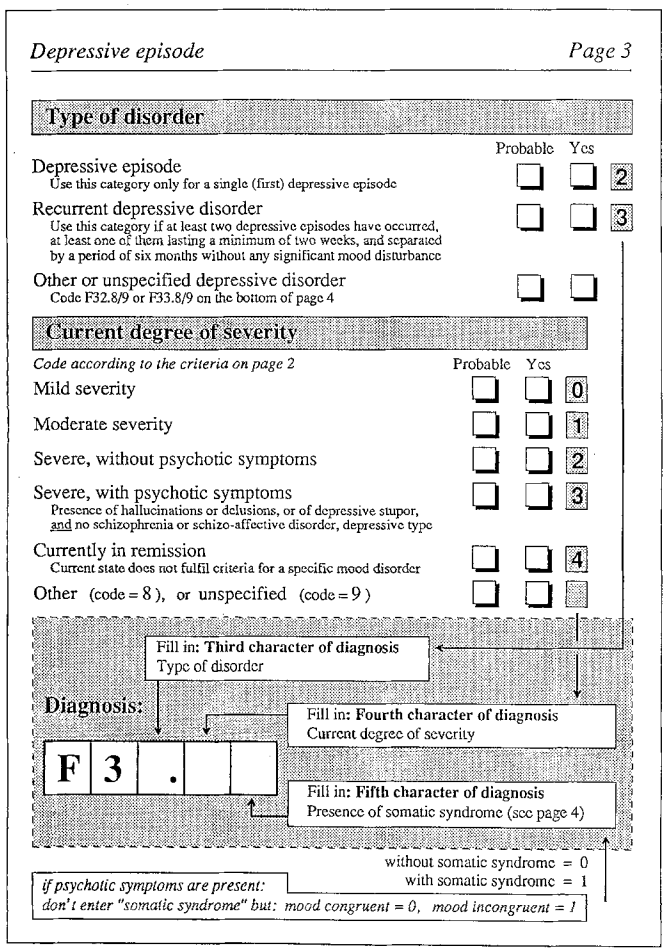

Fig. 2. Section of IDCL "Depressive episode" used to diagnose a single episode or recurrent depressive disorder

ICD-10, followed by separate sections for the specific types of personality disorders. We have decided to include all possible diagnoses in one instrument because criteria from different personality disorders often coexist in individual patients. On the last page of the IDCL-P, the diagnostician can summarize all diagnoses for which criteria were found to be fulfilled.

Unlike with structured interviews, the use of the IDCL and IDCL-P is not restricted to face-to-face explorations. The clinician can consider other sources of information (from members of family, friends and others), previous findings (like hospital reports) or behavioral observations. Information from different sources can be combined when working with the IDCL.

If patients are explored verbally, standardized questioning, probing or a fixed order of progression is not required. The diagnostician is free to give priority to the most prominent complaints as reported by the patient. This procedure corresponds with usual modes of clinical exploration.

In general, the IDCL enable a hypotheses-related procedure. The diagnostician can consider diagnostic hypotheses and "test" them directly during the clinical examination. Assume, for example, that a patient complains of a clinically relevant depressive symptomatology (e.g. with depressed mood, loss of appetite, fatigue and insomnia). On account of the description, the diagnostician may presume (or put forward as a diagnostic hypothesis) that the patient is suffering from a depressive episode as defined by ICD-10 (F32). He can check his hypothesis immediately with the IDCL "Depressive episode". If the criteria for this diagnosis are not fulfilled, it may possibly be dysthymia (F34.1) or adjustment disorder with brief or prolonged depressive reaction (F43.20 or F43.21). In any case, the diagnostician can continue his exploration until he has found an adequate diagnosis for the patient (i.e. an appropriate classification of the depressive symptomatology).

It should be considered during clinical examinations that the psychiatric symptomatology of a patient is to be assessed as completely as possible. If a patient fulfils the diagnostic criteria for more than one disorder, all corresponding diagnoses must be made in any event (according to the concept of comorbidity as proposed by ICD-10).

Experienced clinicians are usually able to use the IDCL without additional training, since most of the diagnostic terms in ICD-10 are well known from traditional diagnostic concepts. However, these psychopathological features must now be considered as diagnostic *criteria* which are to be evaluated in a systematic form before a diagnosis is made. Familiarity with ICD-10 is therefore an important prerequisite for using the checklists.

The IDCL are available in English and German. Among the major disorders in psychiatry, dementia is not covered by the instrument. The examination of demented (or probably demented) patients usually requires a differential neuropsychological assessment of deficits in cognitive functioning. This procedure, along with the resulting diagnostic decision, can be carried out with the help of the *SIDAM* (Structured Interview for the Diagnosis of Dementia of the Alzheimer type, Multi-infarct Dementia, and Dementias of other Etiology according to DSM-III-R and ICD-10; Zaudig et al. 1991) which has also been developed by our team.

Areas of Application

The IDCL are primarily tailored to the requirements of clinical everyday diagnostics. However, the instrument is not limited to this setting and can also be used when examinations are more intense and time-consuming (e.g. inpatient or research diagnostics):

- *Clinical diagnostics and documentation:* A systematization of diagnostic findings can be achieved in usual clinical care. For example, filled out checklists can be enclosed with the patient's data (clinical records and case histories) and thus serve as a standardized and more objective documentation.
- *Education and training:* The IDCL can be used as a teaching tool for residents, students, and nonpsychiatric clinicians. Residents can familiarize themselves with central diagnostic criteria of mental disorders by

using the IDCL as an orientation in their own explorations. The lists can be applied when diagnostic examinations are to be demonstrated and practised.

- *Research:* The instrument can be used to select specific groups of patients for all kinds of psychiatric investigations. It is possible to apply the IDCL in addition to other more structured instruments that are focused on specific diagnoses. If checklists are incorporated into clinical records, future research relying on retrospective chart reviews may be facilitated.

Evaluation of the IDCL

The IDCL were administered by us (under its previous label "MDCL") to a sample of several hundred outpatients with various mental disorders. These data were used for polydiagnostic comparisons (Hiller et al. 1988, 1989a; Hiller 1989), an analysis of overlap between depression and anxiety (Hiller et al. 1989b) and for a systematic evaluation of the DSM-III-R criteria for alcohol dependence (Hiller et al. 1989c).

In further studies, the test-retest reliability of IDCL lifetime diagnoses was investigated. We collected data from 60 adult outpatients with non-psychotic and non-organic disorders (DSM-III-R) who were consecutively examined within our routine conditions (Hiller et al. 1990b). The checklists were administered to each subject on two separate occasions by two different of four participating diagnosticians. Time intervals were kept between one and four days. We obtained satisfactory to excellent diagnostic agreement for most categories with kappa (κ) values ranging above 0.60. For example, κ was 0.80 for alcohol dependence, 0.77 for drug dependence, 0.83 for mood (affective) disorders and 0.76 for anxiety disorders. Overall percentage agreement ranged between 90% and 95% for these categories. We could show that these findings bear comparison with the reliability obtained for standardized interviews.

A second test-retest study by Bronisch et al. (1992) was restricted to the assessment of personality disorders (DSM-III-R). In a sample of 60 inpatients, the diagnostic decision of personality disorders vs. *no* personality disorder reached a reliability of $\kappa = 0.62$. The range of κ values for specific personality disorders which were diagnosed at least five times was from 0.35 to 0.79.

The interrater reliability of major ICD-10 and DSM-III-R diagnoses was further investigated using clinical case records. The results of this study are reported in another article in this volume (see page 209).

Acknowledgements. This work was supported by grant Mo 439/1-3 of the German Research Foundation (Deutsche Forschungsgemeinschaft).

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