

Classification of psychiatric disorders

Any discussion of the classification of psychiatric disorders should begin with the frank admission that the definitive classification of disease must be based on aetiology. Until we know the cause of the various mental illnesses, we must adopt a pragmatic approach to classification that will best enable us to care for our patients, to communicate with other health professionals and to carry out high-quality research.

In physical medicine, syndromes existed long before the aetiology of these illnesses were known. Some of these syndromes have subsequently been shown to be true disease entities because they have one essential cause. Thus, smallpox and measles were carefully described and differentiated by the Arabian physician Rhazes in the 10th century AD. With each new step in the progress of medicine, such as auscultation, microscopy, immunology, electrophysiology, etc., some syndromes have been found to be true disease entities, while others have been split into more discrete entities and others jettisoned. For example, diabetes mellitus has been shown to be a syndrome that can have several different aetiologies. On that basis the modern approach to classification has been to establish syndromes in order to facilitate research and to assist us in extending our knowledge of them so that ultimately specific diseases can be identified. We must not forget that syndromes may or may not be true disease entities and some will argue that the multifactorial aetiology of psychiatric disorder, related to both constitutional and environmental vulnerability, as well as to precipitants, may make the goal of identifying psychiatric syndromes as discrete diseases an elusive ideal.

Syndromes and diseases

A syndrome is a constellation of symptoms that are unique as a group. It may of course contain some symptoms that occur in other syndromes also, but it is the particular combination of symptoms that makes the syndrome specific. In psychiatry, as in other branches of medicine, many syndromes began as one specific and striking symptom. In the 19th century, stupor, furore and hallucinosis were syndromes based on one prominent symptom.

Later, the recognition that certain other signs and symptoms co-occurred simultaneously led to the establishment of true syndromes. Korsakoff's syndrome illustrates the progression from symptom to syndrome to disease. Initially, confabulation and impressibility among alcoholics were recognised by Korsakoff as significant symptoms. Later the presence of disorientation for time and place, euphoria, difficulty in registration, confabulation and 'tram-line' thinking were identified as key features of this syndrome. Finally, the discovery that in the alcoholic amnesic syndrome there was always severe damage to the mammillary bodies confirmed that Korsakoff's psychosis (syndrome) is a true disease with a neuropathological basis.

Sometimes the symptoms of the syndrome seem to have a meaningful coherence. For example, in mania the cheerfulness, the overactivity, the pressure of speech and the flight of ideas can all be understood as arising from the elevated mood. The fact that we can empathise with and understand our patients' symptoms has led to the distinction between those symptoms that are primary and which are said to be the immediate result of the disease process, and secondary symptoms, which are a psychological elaboration of, or reaction to, primary symptoms. The term is also used to describe symptoms that cannot be derived from any other psychological event.

Early distinctions

The first major classification of mental illness was based on the distinction between disorders arising from disease of the brain and those with no such obvious basis, i.e. organic versus functional states. These terms are still used, but as knowledge of the neurobiological processes associated with psychiatric disorders has increased, their original meaning has been lost. Schizophrenia and manic depression are typical examples of functional disorders, but the increasing evidence of the role of genetics and of neuropathological abnormalities shows that there is at least some organic basis for these disorders. Indeed the category of 'organic mental syndromes and disorders' has been renamed as 'delirium, dementia and amnesic and other cognitive disorders' in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)–IV* (American Psychiatric Association, 1994), so that the recognition of the role of abnormal brain functioning is not confined to dementia and delirium only. In their literal meaning these categories of classification (i.e. organic versus functional) are absurd, yet they continue to be used through tradition.

Organic syndromes

The syndromes due to brain disorders can be classified into acute, subacute and chronic. In acute organic syndromes the most common feature is alteration of consciousness, which can be dream-like, depressed or restricted. This gives rise to four subtypes, i.e. delirium, subacute delirium, organic stupor or torpor, and the twilight state. Disorientation, incoherence of psychic life and some degree of anterograde amnesia are features of all of

these acute organic states. In delirium there is a dream-like change in consciousness so that the patient may also be unable to distinguish between mental images and perceptions, leading to hallucinations and illusions. Usually there is severe anxiety and agitation. When stupor or torpor is established the patient responds poorly or not at all to stimuli and after recovery has no recollection of events during the episode. In subacute delirium there is a general lowering of awareness and marked incoherence of psychic activity, so that the patient is bewildered and perplexed. Isolated hallucinations, illusions and delusions may occur and the level of awareness varies but is lower at night-time. The subacute delirious state can be regarded as a transitional state between delirium and organic stupor. In twilight states consciousness is restricted, so that the mind is dominated by a small group of ideas, attitudes and images. These patients may appear to be perplexed but often their behaviour is well ordered and they can carry out complex actions. Hallucinations are commonly present. In organic stupor (torpor) the level of consciousness is generally lowered and the patient responds poorly or not at all to stimuli. After recovery the patient usually has amnesia for the events that occurred during the illness episode.

In addition to the above, there are organic syndromes in which consciousness is not obviously disordered, for example organic hallucinosis due to alcohol abuse, which is characterised by hallucinations, most commonly auditory and occurring in clear consciousness, as distinct from the hallucinations of delirium tremens that occur in association with clouded consciousness. Amnesic disorders, of which Korsakoff's syndrome is but one, also belong in this group of organic disorders and are characterised primarily by the single symptom of memory impairment in a setting of clear consciousness and in the absence of other cognitive features of dementia.

The chronic organic states include the various dementias, generalised and focal, as well as the amnesic disorders. Included among the generalised dementias are Lewy body disease, Alzheimer's disease, etc., while the best known focal dementia is frontal lobe dementia (or syndrome). The latter is associated with a lack of drive, lack of foresight, inability to plan ahead and an indifference to the feelings of others, although there is no disorientation. Some patients may also demonstrate a happy-go-lucky carelessness and a facetious humour, termed *Witzelsucht*, whereas others are rigid in their thinking and have difficulty moving from one topic to the next. The most common cause is trauma to the brain such as occurs in road traffic accidents. The presence of frontal lobe damage may be assessed psychologically using the Wisconsin Card Sorting test or the Stroop test. Amnesic disorders are chronic organic disorders in which there is the single symptom of memory impairment; if other signs of cognitive impairment are present (such as disorientation or impaired attention) the diagnosis is dementia. The major neuroanatomical structures involved are the thalamus, hippocampus, mammillary bodies and the amygdala. Amnesia is usually the result of bilateral damage but some cases can occur with unilateral damage and the left hemisphere appears to be more critical than the right in its genesis.

Functional syndromes

Functional disorders, a phrase seldom used nowadays, refers to those syndromes in which there is no readily-apparent coarse brain disease, although increasingly it is recognised that some finer variety of brain disease may exist, often at a cellular level.

For many years it was customary to divide these functional mental illnesses into neuroses and psychoses. The person with neurosis was believed to have insight into his illness, with only part of his personality involved in the disorder, and to have intact reality testing. The individual with psychosis, on the other hand, was believed to lack insight, had the whole of his personality distorted by the illness and constructed a false environment out of his distorted subjective experience. However, such differences are an oversimplification, since many individuals with neurotic conditions have no insight, and far from accepting their illness, may minimise or deny it totally, while people with schizophrenia may seek help willingly during or before episodes of relapse. Moreover, personality can be changed significantly by non-psychotic disorders such as depressive illness, while it may be intact in some people with psychotic disorders such as persistent delusional disorder.

Jaspers (1962) regarded the person with neurosis as an individual who has an abnormal response to difficulties in which some specific defence mechanism has transformed their experiences. For example, in conversion and dissociative disorders (formerly hysteria) the mechanism of dissociation is used to transform the emotional experiences into physical symptoms. Since we can all use this mechanism, the differences between the neurotic person and the normal person is one of degree. Schneider (1959) has suggested the neuroses and personality disorders are variations of human existence that differ from the norm quantitatively rather than qualitatively. However, this view of the neuroses breaks down when obsessive-compulsive disorder is considered, since the symptoms are not variations of normal but differ qualitatively from normal behaviours.

Over time the use of the terms neurotic and psychotic changed and instead of describing symptoms, particularly symptom types such as hallucinations or delusions, in the psychotic person they were used to distinguish mild and severe disorders or to distinguish those symptoms that were ego-syntonic (i.e. creating no distress for the person or compatible with the individual's self-concept or ego) or ego-dystonic (i.e. causing distress and incompatible with the person's self-concept). Some practitioners also used the word 'neurotic' as a term of opprobrium. Owing to the confusion that abounded in the various uses of these terms, DSM-IV has excluded the term 'neurosis' totally from its nomenclature and International Classification of Diseases (ICD)-10 (World Health Organization, 1992) has limited its use to a group of disorders entitled 'neurotic, stress-related and somatoform disorders'.

Personality disorders and psychogenic reactions

The status of personality disorder vis-à-vis other psychiatric disorders was historically regarded differently in the English-speaking world compared with the rest of the world. In the English-speaking world, it was customary to separate the neuroses from personality disorders, but in the German-speaking countries, epitomised by Schneider, the neuroses were regarded as reactions of abnormal personalities to moderate or mild stress and of normal personalities to severe stress. This difference in approach continues and is reflected in the differing approaches to personality disorder in DSM and ICD, with the former placing personality disorder on a separate axis from other disorders, while ICD–10 represents both on Axis I (see below).

Psychogenic reactions constituted reversible prolonged psychological responses to trauma, the reactions being the consequence of the causative agent on the patient's personality. Thus acute anxiety and hysteria were considered to be varieties of psychogenic reactions provoked by stress and determined by personality and cultural factors. Sometimes the stress was believed to cause psychotic reactions, termed symptomatic or psychogenic psychoses; for example the person with a paranoid personality who, in light of ongoing marital difficulties, begins to suspect his wife's fidelity, finally becoming deluded about this. The idea of delusional states that were not due to functional psychoses was treated with skepticism by English-speaking psychiatrists, but had adherents in Scandinavia, particularly in what were termed psychogenic psychoses. These have gained increasing acceptance and are now called acute and transient psychotic disorders in ICD–10 and brief psychotic disorder with or without marked stressors in DSM–IV.

In summary, Schneider (1959) considered that neuroses, psychogenic reactions and personality disorders were not illnesses in the sense that there was a morbid process in the nervous system, while he considered that functional psychoses did represent true illnesses.

Modern classifications

The 4th edition of the DSM (DSM–IV) (American Psychiatric Association, 1994) is the most recently published classification of mental disorders, although there has been a more recent text revision of the manual, entitled DSM–IV–TR (2000). DSM–IV is used in the USA and notwithstanding the fact that the World Health Organization has developed the 10th edition of the ICD (ICD–10) (World Health Organization, 1992), the latter has found little usage in the USA, although it remains the main classification used in Britain, Ireland and almost the whole of Europe.

DSM–I, published by the American Psychiatric Association, first appeared in 1952 and since then it has evolved significantly, to the extent that DSM–IV includes large amounts of detail concerning each syndrome and, owing to its rigorous adherence to operational definitions for each disorder, it is suitable for use in both clinical practice and research. For this reason

DSM–IV is considerably less user-friendly than ICD–10 and is also considered excessively procrustean by its critics. Interestingly, the billing codes for Medicare in the USA are mandated to follow the ICD system rather than their own DSM–IV.

ICD–10 on the other hand is more clinically orientated and is not so rigid in its definitions, eschewing operational definitions in favour of general descriptions. It allows clinical judgement to inform diagnoses, but this freedom makes it unsuitable for research purposes, necessitating the development of separate research diagnostic criteria. Thus, different versions of ICD–10 now exist and these include the clinical version (World Health Organization, 1992), a version with diagnostic criteria for research (World Health Organization, 1993) (which resembles DSM in its use of detailed operational criteria) and a version for use in primary care (ICD–10–PC; World Health Organization, 1996), the latter consisting of definitions for 25 common conditions as well as a shorter version of 6 disorders for use by other primary care workers. Management guidelines incorporate information for the patient as well as details of medical, social and psychological interventions. Finally, assistance on when to refer for specialist treatment is provided.

DSM–IV also has a primary care version (DSM–IV–PC) that is similar to ICD–10–PC, focusing on the most common disorders seen in primary care (anxiety, depression, substance misuse, etc.).

Although both ICD–10 and DSM–IV are broadly similar, the language used to describe each disorder differs significantly. The differences, both in general approach and in language, are illustrated in the descriptions of depressive episode (see Boxes 1.1 and 1.2).

Comparison of DSM–IV and ICD–10

It is important to recognise that DSM–IV and ICD–10 are syndrome-based classifications, but as our knowledge increases, some classifications currently included may be removed or new categories may be added. For example, depressive personality disorder is not included in ICD–10 and is only incorporated in the section of DSM–IV entitled ‘Criteria sets and axes provided for further study’. On the other hand, passive–aggressive personality disorder was included in DSM–III but excluded from the subsequent edition, and has never been incorporated into the ICD system.

ICD–10 does not distinguish bipolar I and II disorder, as does DSM–IV, as these conditions have only come to be recognised in the 1990s. Recurrent brief depressive disorder is a new addition to ICD–10 but only appears in the appendix of DSM–IV. Schizotypal disorder is classified with the schizophrenic disorders in ICD–10 and with the personality disorders in DSM–IV. Any belief, therefore, that the categories incorporated in either system of classification are ‘writ in stone’ is deeply misplaced.

There are also differences in the number of axes used (see below) in each and in the level of operational definition (as mentioned above).

Box 1.1 DSM–IV–TR Criteria for major depressive episode
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DSM–IV–TR Criteria for Major Depressive Episode

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

- (1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). Note: in children or adolescents, can be irritable mood
- (2) markedly diminished interest or pleasure in all, or almost all, activities of the day, nearly every day (as indicated by either subjective account or observation made by others)
- (3) significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains
- (4) insomnia or hypersomnia nearly every day
- (5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
- (6) fatigue or loss of energy nearly every day
- (7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
- (8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
- (9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

B. The symptoms do not meet criteria for a Mixed Episode (see p. 365)

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

Box 1.2 ICD–10 Depressive episode criteria (World Health Organization, 1993. Reprinted by permission.)

F32 Depressive episode

- G1. The depressive episode should last for at least 2 weeks.
- G2. There have been no hypomanic or manic symptoms sufficient to meet the criteria for hypomanic or manic episode (F30.–) at any time in the individual's life.
- G3. *Most commonly used exclusion clause.* The episode is not attributable to psychoactive substance use (F10–F19) or to any organic mental disorder (in the sense of F00–F09).

Somatic syndrome

To qualify for the somatic syndrome, four of the following symptoms should be present:

- (1) marked loss of interest or pleasure in activities that are normally pleasurable;
- (2) lack of emotional reactions to events or activities that normally produce an emotional response;
- (3) waking in the morning 2 hours or more before the usual time;
- (4) depression worse in the morning;
- (5) objective evidence of marked psychomotor retardation or agitation (remarked on or reported by other people);
- (6) marked loss of appetite;
- (7) weight loss (5% or more of body weight in the past month);
- (8) marked loss of libido.

F32.0 Mild depressive episode

- A. The general criteria for depressive episode (F32) must be met.
- B. At least two of the following three symptoms must be present:
 - (1) depressed mood to a degree that is definitely abnormal for the individual, present for most of the day and almost every day, largely uninfluenced by circumstances, and sustained for at least 2 weeks;
 - (2) loss of interest or pleasure in activities that are normally pleasurable;
 - (3) decreased energy or increased fatigability.
- C. An additional symptom or symptoms from the following list should be present, to give a total of at least *four*:
 - (1) loss of confidence or self-esteem;
 - (2) unreasonable feelings of self-reproach or excessive and inappropriate guilt;
 - (3) recurrent thoughts of death or suicide, or any suicidal behaviour;
 - (4) complaints or evidence of diminished ability to think or concentrate, such as indecisiveness or vacillation;
 - (5) change in psychomotor activity, with agitation or retardation (either subjective or objective);
 - (6) sleep disturbance of any type;
 - (7) change in appetite (decrease or increase) with corresponding weight change.

F32.1 Moderate depressive episode

- A. The general criteria for depressive episode (F32) must be met.
- B. At least two of the three symptoms listed for F32.0, criterion B, must be present.
- C. Additional symptoms from F32.0, criterion C, must be present, to give a total of at least *six*.

continued

Box 1.2 *continued***F32.2 Severe depressive episode without psychotic symptoms**

Note: If important symptoms such as agitation or retardation are marked, the patient may be unwilling or unable to describe many symptoms in detail. An overall grading of severe episode may still be justified in such a case.

- A. The general criteria for depressive episode (F32) must be met.
- B. All three of the symptoms in criterion B, F32.0, must be present.
- C. Additional symptoms from F32.0, criterion C, must be present, to give a total of at least *eight*.
- D. There must be no hallucinations, delusions, or depressive stupor.

F32.3 Severe depressive episode with psychotic symptoms

- A. The general criteria for depressive episode (F32) must be met.
- B. The criteria for severe depressive episode without psychotic symptoms (F32.2) must be met with the exception of criterion D.
- C. The criteria for schizophrenia (F20.0–F20.3), or schizoaffective disorder, depressive type (F25.1) are not met.
- D. Either of the following must be present:
 - (1) delusions or hallucinations, other than those listed as typically schizophrenic in criterion G1(1)b, c, and d for F20.0–F20.3 (i.e. delusions other than those that are completely impossible or culturally inappropriate and hallucinations that are not in third person or giving a running commentary); the commonest examples are those with depressive, guilty, hypochondriacal, nihilistic, self-referential, or persecutory content;
 - (2) depressive stupor.

F32.8 Other depressive episodes**F32.9 Depressive episode, unspecified****DSM–IV**

DSM–IV lists and operationally defines over 300 psychiatric disorders. Each disorder is systematically described in terms of its associated features such as age, gender and culture-related features, incidence risk and predisposing factors. Differential diagnosis is also included. Where relevant, laboratory findings are also described. However, this system is atheoretical and no consideration of causes or treatment is included, nor are controversies surrounding particular diagnoses outlined. It is therefore not a textbook. It also incorporates disorders that are worthy of further scientific examination.

As well as providing detailed criteria for each disorder, DSM–IV is multiaxial in its diagnostic approach, leading to patient evaluation on each of 5 dimensions or axes as follows:

- Axis I Current mental state diagnosis (definite or provisional)
- Axis II Personality disorder and mental retardation

- Axis III Any physical condition whether related or not to the psychiatric disorder
- Axis IV Psychosocial or environmental factors contributing to the disorder
- Axis V Global Assessment of Functioning (GAF) scale. This is a measure of functioning at a specified time, for example at time of evaluation, highest level of functioning during past 6 months, at time of discharge, etc. This 100-point scale provides a composite measure of psychological, social and occupational functioning. It excludes impairment due to physical or environmental limitations.

In addition, the disorders can be described as mild, moderate or severe, and as possibly being in partial or full remission. Where there is more than one Axis I diagnosis, they are listed in order of the focus of clinical attention. In addition, DSM–IV is hierarchical, so that some diagnoses subsume others, for example if the criteria for schizophrenia and for panic are met, the diagnosis listed is schizophrenia. Organic disorders override psychotic disorders, and these in turn subsume non-psychotic diagnoses. Affective disorders override anxiety disorders. Finally, DSM–IV incorporates, in its appendix, decision trees or algorithms to facilitate diagnosis. A diagnosis can be deemed provisional if there is a strong presumption that the full criteria for the disorder will ultimately be met even though at the time of evaluation it is not possible to make a definitive diagnosis.

ICD–10

This system is now in use throughout Europe and it reflects a significant advance on its predecessor. Many confusing terms such as ‘neurotic’ are confined to a single category of ‘neurotic, stress-related and somatoform disorders’, and the older distinction between neurotic and psychotic has been replaced by a classification according to major common themes, for example, mood (affective) disorders (F30–39) and schizophrenia, schizotypal and delusional disorders (F20–29). Childhood disorders have also been incorporated under two broad categories, i.e. disorders of psychological development (F80–89) and behavioural and emotional disorder with onset usually occurring in childhood and adolescence (F90–98). The classification of mental retardation (F70–79) is still rudimentary and is expected to become more comprehensive in subsequent editions.

ICD–10 includes a multi-axial approach although it is somewhat different from DSM in that only 3 axes are recognised and personality disorder is not separated from other mental state disorders. This system also recommends that where multiple Axis I diagnoses coexist (comorbidity) all should be recorded, beginning with the most prominent. Like DSM–IV, ICD–10 is also hierarchical, although diagnostic decision trees are not provided and operational definitions are less rigid than in DSM, allowing for the precedence of clinical judgement.

The axes in ICD–10 are as follow:

- Axis I Current mental state diagnosis including personality disorder
- Axis II Disabilities
- Axis III Contextual factors.

Diagnoses may be made with confidence when the diagnostic guidelines are clearly fulfilled. However, if they are only partially met or more information is required the diagnosis may be ‘provisional’, and the diagnosis is ‘tentative’ if further information is unlikely to become available. Although guidelines concerning duration are also provided in the criteria, these are not intended as strict requirements and clinicians should use their own judgement when assigning a particular diagnosis if the duration of particular symptoms is slightly shorter or longer than specified.

Interview schedules

In order to carry out epidemiological studies in which diagnoses are standardised, diagnostic interview schedules have been developed that meet the criteria for ICD–10 and DSM–IV diagnoses. In Europe the Schedule for Clinical Assessment in Neuropsychiatry (SCAN) (Wing *et al*, 1990) has evolved from the older Present State Examination (PSE) (Wing *et al*, 1974). SCAN itself is a set of instruments aimed at assessing and classifying psychopathology in adults. The four instruments include PSE–10 (the 10th edition of the Present State Examination), the SCAN glossary, which defines the symptoms; the Item Group Checklist (IGC) for symptoms that can be rated directly (for example from case notes), and the Clinical History Schedule (CHS). This instrument provides diagnoses according to both ICD–10 and DSM–IV criteria. The interview itself is semi-structured, the aim being to encapsulate the clinical interview while minimising its vagaries. There are probe questions with standard wording to elucidate the psychopathological symptoms, defined in the glossary and accompanied by severity ratings. Where there is doubt, the interviewer can proceed to a free-style interview to clarify the feature further and may, if necessary, include the patient’s phraseology in questioning to enhance clarity. It is designed for use by psychiatrists or clinical psychologists, thereby utilising clinical interviewing skills in evaluating each symptom. The symptoms ratings, provided they have been identified as defined in the glossary, are then entered into a computer algorithm and a computer diagnosis obtained according to either classification. The role of the interviewer is thus to rate symptoms rather than make diagnoses. SCAN can generate a current diagnosis, a lifetime diagnosis or a representative episode diagnosis. The use of mental health professionals in interviewing with SCAN makes this an expensive method but has the advantage of approximating the ‘gold standard’ diagnosis achieved by clinical interview.

The DSM–IV equivalent, the Composite International Diagnostic Interview (CIDI) (Robins *et al*, 1989) developed from the Diagnostic Interview Schedule (DIS) (Robins *et al*, 1985), is not a semi-structured interview, but a standardised one, suitable for use with lay interviewers. No clinical judgement is brought to bear in rating the symptoms since questions are asked in a rigid and prescribed manner. The questions are clearly stated to elicit symptoms, followed by questions about frequency, duration and severity. The only judgement the interviewer has to make is whether the respondent understood the question, and if not, it is repeated verbatim. CIDI is available in computer format also and so can be self-administered. As with SCAN, the symptoms are then entered into a computer algorithm for diagnosis according to ICD–10 or DSM–IV. The advantage of this approach is that it is cheaper than using semi-structured interviews, since lay people can be trained in its use. However, the absence of clinical judgement is an obvious disadvantage that has resulted in its validity being questioned. Some recent reviews question the prevalence for some psychiatric disorders obtained using standardised interviews such as CIDI and suggest that the high rates identified in some studies require revision downwards (Regier *et al*, 1998). These mutually different approaches are discussed in detail by Brugha *et al* (1999) and by Wittchen *et al* (1999).

Interviews such as SCAN pay little attention to personality disorder and it is only in the clinical history section that details of diagnoses not covered in PSE–10 are recorded, usually from other sources of information. Likewise CIDI also pays limited attention to personality disorders. Individual categories such as adjustment disorder are only incorporated peripherally in SCAN and not at all in CIDI, thus limiting their usefulness in certain populations where these categories may be common, for example, in primary care and general medical populations respectively.

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