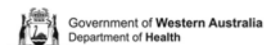
CENTRE FOR CLINICAL RESEARCH IN NEUROPSYCHIATRY



Gascoyne House, John XXIII Avenue, Mt Claremont, WA 6010
Mail: PO Private Bag No. 1, Claremont WA 6910 Tel: (08) 9347-6429 Fax: (08) 9384-5128
http://www.health.wa.gov.au/ccrn/

Diagnostic Interview for Psychoses (DIP)

updated 23/12/2009

1. Introduction 2
2. Demographic and social function module (DIP-DSFM) 2
3. Diagnostic module (DIP-DM) 2
4. Service utilisation module (DIP-SUM) 3
5. DIP reliability and validity 3
6. DIP-DM software 3
7. The DIP Training Package 4
8. Sample diagnostic printout 5
9. Rating Scales OPCRIT 4 for DIP-DM Version 4.x (16/82007) 6
10. References and bibliography 8
11. Contact for further information 9

1. Introduction

The DIP is a semi-structured interview for psychosis for use in epidemiological and clinical settings. It is designed to provide a diagnosis, as well as to assess symptom profiles (present state, past year and lifetime), social functioning, disablement, and service utilisation. The DIP was developed specifically for the National Mental Health Survey – Low Prevalence (Psychotic) Disorders Study, conducted in Australia from 1997 to 1998 (Jablensky et al, 1999, 2000). It is a semi-structured clinical interview and includes three modules – (i) Demography and social functioning module (DIP-DSFM); (ii) Diagnostic module (DIP-DM); and (iii) Service Utilisation module (DIP-SUM). The DIP is designed for administration by mental health professionals. It is possible to do a DIP on the basis of comprehensive casenotes only. The DIP is currently undergoing further modifications as part of the 2010 Australian National Survey of High Impact Psychosis (SHIP). Further information on the SHIP-DIP is available from A/Prof Anna Waterreus: annaudp@cyllene.uwa.edu.au.

2. Demographic and social function module (DIP-DSFM)

The demography and social functioning module includes selected items from the World Health Organization Disability Assessment Schedule (World Health Organization, 1988). This is supplemented by sections of the Lancashire Quality of Life Profile (Oliver et al, 1997) and the Current Social Contacts Scale described by Tucker (1982). In addition, a global rating is made using the Social and Occupational Functioning Scale (American Psychiatric Association, 1994).

Apart from standard demographic material (e.g. age, sex, marital status), the DIP includes items related to migrant status, family and household, education, and accommodation. In relation to accommodation, respondents are also asked whether they feel safe in their current neighbourhood or locality and whether they have been a victim of violence in the last 12 months. Aspects of social functioning, disability and impairment in key role domains are assessed by rating performance of household duties, general social contact isolation and withdrawal, access to friends and family, and intimacy. A set of 14 items explores participation in the workforce and perceived capacity for work (including housework and studying). Items related to finances, activities of daily living, self-care and use of leisure time are also examined.

3. Diagnostic module (DIP-DM)

The Diagnostic Module is designed around the Operational Criteria Checklist for Psychosis (OPCRIT), a 90-item checklist linked to a computerised diagnostic algorithm which has been widely used internationally (McGuffin, 1991; Williams, 1996). While the original OPCRIT does not specify a procedure for eliciting the information necessary for rating the diagnostic items, the DIP-DM module includes a structured clinical interview with questions and optional probes derived and adapted from the World Health Organization Schedules for Clinical Assessment in Neuropsychiatry (SCAN, version 2.1 - Wing, 1990). Lifetime, past year and present state ratings for the items of the DIP-DM are possible. The computer algorithm associated with OPCRIT uses the interview data to generate diagnoses. The OPCRIT computer algorithm is capable of generating diagnoses under a number of classification systems such as DSM-IV, ICD-10 and RDC. The DIP-DM also assesses comorbidity including drug and alcohol abuse/dependence. Diagnostic Interview For Psychosis (Diagnostic Module) has good reliability and validity and its psychometric properties have been published (Castle, 2006).

The ratings for the DIP-DM require more than a simple present or absent judgement and presuppose a level of clinical skill in the interviewer. Specific training is necessary to ensure reliability of ratings.

4. Service utilisation module (DIP-SUM)

Since people with psychotic disorders are known to be high users of a large number of services, the service utilisation module of the DIP aims to capture, in a self-report format, as comprehensively as possible a variety of services likely to be used by this population, and to quantify the extent of their use in the year prior to the interview. Hospitalisation, both psychiatric and non-psychiatric, public and private, is recorded as well as visits to accident and emergency departments, and number of contacts with psychiatric emergency or crisis services, both hospital and community based. The number and type of continuing care visits in the community or clinics are recorded together with the type of health professional assigned as the patient's case manager. Other health professionals seen and services received, both psychiatric and non-psychiatric are noted, including whether the services met the patient's perceived needs. Involvement in rehabilitation or day programs is recorded as well as access to, and use of, government and non-government health and welfare agencies. Further information recorded in the interview includes availability of carers, legal guardianship and detailed information regarding medication. The concluding part of the module aims to elicit subjective quality of life judgements (satisfaction with own independence and satisfaction “with life as a whole’ in the past year) as well as an open-ended account of perceived need for services that were unavailable.

5. DIP reliability and validity

There has been a comprehensive assessment of the reliability and validity of the DIP. The Diagnostic Interview for Psychosis (Diagnostic Module) has good reliability and validity and its psychometric properties have been published: Castle D, Jablensky A, McGrath J, Carr V, Morgan VA, Waterreus A, et al. The Diagnostic Interview for Psychoses (DIP): Development, Reliability and Applications. Psychol Med 2006; 36:69-80. This publication is available for download at this site

6. DIP-DM software

The DIP-DM software was written to allow data entry onto a DBASE database of the information elicited using the Diagnostic Module. Once the data have been entered, the DIP-DM generates diagnoses according to the various operational definitions functional in the OPCRIT diagnostic algorithm. There are in-built validation rules that ensure the quality of the data being entered. The database stores both the diagnostic data and the raw data, ready for export into other software for manipulation or analysis. The clinician entering the data can have an immediate diagnostic printout, or the data can be stored for later analysis. The data can also be viewed directly on screen.

7. The DIP Training Package

While the DIP presupposes a certain level of clinical expertise, persons with minimal clinical background may be trained to a reasonable level of competence. Specific training for all users of the DIP is essential to ensure reliability of ratings.

The DIP training program includes an introduction to the concepts underlying the DIP, coverage of the glossary items, guidance on how to use the software, co-rating of video-recorded interviews, as well as in vivo interviews with psychiatric patients. Trainees are then encouraged to complete further interviews on their own, with direct feedback provided by the trainer. Trainees get a competency certificate when a reasonable level of inter-rater reliability is reached. As part of the training package, trainees receive the DIP-DM software and a comprehensive manual complete with software instructions and glossary.

Ongoing support is offered to users of the DIP as well as refresher courses and, more recently, a ‘train the trainer’ program has been introduced. Training seminars have been provided on group and individual bases for mental health professionals and postgraduate research students. Training by correspondence has been provided for a number of interested clinicians outside Australia.

The training program for the DIP has undergone close scrutiny over the last few years with the aim of developing a standardised ‘hands on’ training package. Consumer feedback has been actively sought and standardised consumer feedback questionnaires are completed at the end of each training program. Feedback provided impromptu by trainees throughout the training seminars is also incorporated in changes to the comprehensive manual as well as the training program itself.

The popularity of the DIP is due to the simplicity of training, ease and brevity of administration, and its ability to provide an almost immediate diagnosis. While the majority of research projects use the DIP to provide a lifetime diagnosis, many practising clinicians are now using the DIP to track changes in symptomatology over time, making it a useful tool for clinical practice.

For information on the DIP-DM training seminar program, contact

Prof Assen Jablensky
Phone: +61 8 9224 0290
Email: assen@cyllene.uwa.edu.au

Assistant Prof Anna Waterreus
School of Psychiatry & Clinical Neurosciences
Centre for Clinical Research in Neuropsychiatry,
Private Bag #1, Mt Claremont, Western Australia 6910
Phone: +61 8 9347 6438
E-mail: annaudp@cyllene.uwa.edu.au

8. Sample diagnostic printout

Diagnostic score based on LIFETIME Ratings

ICD-10	12	paranoid schizophrenia
DSM-IIIR	12	schizophrenia
Research Diagnostic Criteria	8	narrow schizophrenia

DSM-III	9	schizophrenia
Feighner et al	4	probable schizophrenia
Carpenter	1	'level 5' schizophrenia
Schneider FRS	1	frs-schizophrenia
French classification	1	interpretive psychosis
Taylor Adams	4	schizophrenia
Tsuang-Winokur subtypes	1	paranoid
Crow subtypes	1	type 1
Farmer subtypes	1	'p' type

Confounding Factors	1	alcohol / drug abuse

9. Rating Scales OPCRIT 4 for DIP-DM Version 4.x (16/82007)

ICD-10

1 Mild depression disorder
2 Moderate depression disorder
3 Moderate depression with somatic syndrome
4 Severe depression disorder
5 Severe depression with psychotic symptoms syndrome
6 Hypomania
7 Mania
8 Mania with psychosis
9 Bipolar Affective disorder
10 No longer used
11 Schizophrenia
12 Schizoaffective disorder, manic type
13 Schizoaffective disorder, depressed type
14 Schizoaffective disorder, bipolar type
15 Delusional disorder
16 Other non-organic psychotic disorders

DMS-IV

1 Major depressive disorder
2 Major depressive disorder, moderate
3 Major depressive disorder, severe
4 Major depressive disorder with psychosis
5 Hypomanic episode
6 Manic episode
7 Manic episode with psychosis
8 Schizophrenia
9 Schizophreniform disorder
10 Schizoaffective disorder, depressed type
11 Schizoaffective disorder, bipolar type
12 Delusional disorder
13 Psychotic disorder not otherwise specified (atypical psychosis)
14 Bipolar I disorder
15 Bipolar II disorder

DSM-IIIR

1 Major depressive disorder
2 Major depressive disorder, moderate
3 Major depressive disorder, severe
4 Major depressive disorder with psychosis
5 Hypomanic episode
6 Manic episode
7 Manic episode with psychosis
8 Schizophrenia
9 Schizophreniform disorder
10 Schizoaffective disorder, depressed type
11 Schizoaffective disorder, bipolar type
12 Delusional disorder
13 Psychotic disorder not otherwise specified (atypical psychosis)
14 Bipolar disorder

DSM-III
1 Major depression
2 Mania
3 BP disorder
4 Mania with psychosis
5 Depression with psychosis
6 Bipolar with psychosis
7 Atypical psychosis
8 Schizophreniform
9 Schizophrenia
10 Paranoid disorder

SCHNEIDER FRS
1 Frs-schizophrenia

TAYLOR & ABRAMS
1 Depression
2 Mania
3 BP disorder
4 Schizophrenia

FEIGHNER
1 Depression
2 Mania
3 Bipolar
4 Probable schizophrenia
5 Definite schizophrenia
6 Schizophrenia with secondary affective disorder-mania
7 Schizophrenia with secondary affective disorder-depression
8 Schizophrenia with secondary affective disorder-bipolar

CARPENTER
1 'level 5' schizophrenia
2 'level 6' schizophrenia

FRENCH Classification
1 Interpretive psychosis
2 Chronic hallucinatory psychosis
3 Delusional attack
4 Chronic schizophrenia
5 Bouffee delirante

RDC
1 Major depression
2 Mania
3 Bipolar I
4 Schizo-affective / manic
5 Schizo-affective / depressive
6 Schizo-affective / bipolar
7 Broad schizophrenia
8 Narrow schizophrenia
9 Unspecified functional psychosis
10 Hypomania
11 Bipolar II

Sub-types

CROW
1 Type I
2 Mixed type
3 Type II

FARMER
1 P type
2 H type

TSUANG & WINOKUR
1 Paranoid
2 Undifferentiated
3 Hebephrenic

Confounding Factors

Lifetime diagnosis of alcohol abuse / dependence (q78)
Lifetime diagnosis of cannabis abuse / dependence (q79)
Lifetime diagnosis of other abuse / dependence (q80)
Alcohol / drug abuse within 1 year of onset (q12)
Alcohol abuse / dependence with psychopathology (q81)
Cannabis abuse / dependence with psychopathology (q82)
Other abuse / dependence with psychopathology (q83)
Coarse brain disease prior to onset (q15)

10. References and bibliography

American Psychiatric Association. (1994). Diagnostic and Statistical Manual of Mental Disorders. American Psychiatric Association, Washington DC.

Carpenter, W.T., Strauss, J.S., Bartko, J.J. (1973). Flexible system for the diagnosis of schizophrenia: a report from the WHO Pilot Study of Schizophrenia. Science, 182, 1275.

Castle D, Jablensky A, McGrath J, Carr V, Morgan VA, Waterreus A, et al. The Diagnostic Interview for Psychoses (DIP): Development, Reliability and Applications. Psychol Med 2006; 36:69-80

Crow, T.J. (1980). The molecular pathology of schizophrenia: more than one disease process? British Medical Journal, 280, 66-68.

Feighner, J.P., Robins, E., Guze, S.B., Woodruffe, R.A., Winokur, G. & Munoz, R. (1972). Diagnostic criteria for use in psychiatric research. Archives of General Psychiatry, 26, 57-67.

Jablensky, A., McGrath, J., Herrman, H., Castle, D., Gureje, O., Evans, M., Carr, V., Morgan, V., Korten, A. & Harvey, C. (2000). Psychotic disorders in urban areas: An overview of the Study on Low Prevalence Disorders. Australian and New Zealand Journal of Psychiatry, 34, 221-236.

Jablensky, A., McGrath, J., Herrman, H., Castle, D., Gureje, O., Morgan, V. & Korten, A. (1999). People living with psychotic illness: An Australian study 1997-98. Canberra: Commonwealth of Australia.

McGuffin, P., Farmer, A. & Harvey, I. (1991). A polydiagnostic application of operational criteria in studies of psychotic illness. Development and reliability of the OPCRIT system. Archives of General Psychiatry, 48, 764-770.

Oliver, J.P., Huxley, P.J., Priebe, S. & Kaiser, W. (1997). Measuring the quality of life of severely mentally ill people using the Lancashire Quality of Life Profile. Social Psychiatry and Psychiatric Epidemiology, 32, 76-83.

Pichot, P.J. (1984). The French approach to psychiatric classification. British Journal of Psychiatry, 144, 113-118.

Pull, M.C., Pull, C.B. & Pichot, P. (1987). Des criteres empiriques francais pour les psychoses, II: consensus des psychiatres francais et definitions provisories. Encephale, 13, 53-57.

Spitzer, R.L., Endicott, J. & Robins, E. (1975). Research Diagnostic Criteria, Instrument No. 58. New York, NY: New York State Psychiatric Institute.

Taylor, M.A. & Abrams, R. (1978). The prevalence of schizophrenia: a reassessment of using modern diagnostic criteria. American Journal of Psychiatry, 135, 945-948.

Tsuang, M.T. & Winokur, G. (1974). Criteria for subtyping schizophrenia. Archives of General Psychiatry, 31, 43-47.

Tucker, M.B. (1982). Social support and coping: applications for the study of female drug abuse. Journal of Social Issues, 38, 117-137.

Williams J, Farmer A, Acjenheil M, Kaufmann C, McGuffin P. A multicentre inter-rater reliability study using the OPCRIT computerized diagnostic system. Psychol Med 1996; 26:775-783

Wing, J.K., Babor, T., Brugha, T., Burke, J., Cooper, J.E., Giel, R., Jablensky, A., Regier, D. & Sartorius, N. (1990). SCAN: Schedules for Clinical Assessment in Neuropsychiatry. Archives of General Psychiatry, 47, 589-593.

World Health Organization, (1988). WHO Psychiatric Disability Assessment Schedule (WHO/DAS). World Health Organization, Geneva.

11. Contact for further information

Assistant Prof Anna Waterreus
School of Psychiatry & Clinical Neurosciences
Centre for Clinical Research in Neuropsychiatry,
Private Bag #1, Mt Claremont, Western Australia 6910
Phone: +61 8 9347 6438
E-mail: annaudp@cyllene.uwa.edu.au