The Florence Psychiatric Interview

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ABSTRACT *The Florence Psychiatric Interview (FPI) is an interviewing instrument for evaluating psychopathology in the community. The FPI is designed to be completed by clinical interviewers, and focuses on single episodes of illness where the symptoms are assessed and graded according to their severity on five-point scales. Psychiatric symptoms are evaluated regardless of their diagnostic collocation, and period and lifetime diagnoses may be generated by combining the episodes and using the appropriate algorithms (the information provided by the FPI covers the requirements of all the present diagnostic systems). Other aspects of psychiatric disorders that are usually ignored in other interviews are investigated (for example, costs of illness, use of health facilities, life events, and personality traits).*

Data on reliability (inter-rater agreement and test-retest reliability) and agreement with other instruments such as the Composite International Diagnostic Interview (CIDI) and the Structured Clinical Interview for the Diagnostic and Statistic Manual of Mental Disorders (SCID) seem encouraging. The FPI's ability to collect lifetime symptoms by combining episodes matches that of an interview (the CIDI) that uses the lifetime approach. Agreement between fully qualified psychiatrists and trained residents was excellent. The ability of the cases to recall symptoms experienced several years before was also acceptable. This instrument is therefore proposed for clinical studies at the epidemiological level.

Key words: Florence Psychiatric Interview, FPI, psychopathology, interviews

Introduction

Since Kraepelin's work, psychiatric studies have been conducted almost exclusively on clinical samples and present knowledge still derives almost entirely from the observation of psychiatric patients.

Recent epidemiological studies carried out at the community level, however, have shown that a relatively small number of the subjects affected by psychiatric disorders are referred to psychiatrists. This raises two considerations:

- it is questionable whether information gathered in selected and possibly biased samples may be generalized to all psychiatric disorders (for example, in terms of the clinical picture, onset, natural course, and response rate);
- there are disorders for which the knowledge of psychiatry is still scant, because these patients are rarely observed by psychiatrists.

For this reason, naturalistic observation of psychopathological phenomena in the community by psychiatrists using typical clinical assessment methods could add valuable information.

When we planned a clinical study on a community sample with the purpose of observing psychiatric symptoms, their aggregations, associations and course in a naturalistic setting and irrespective of classifying models, we had to find assessment instruments suited to our requirements. In fact, it is generally accepted that the use of standardized assessment instruments is preferable in terms of reliability, stability and completeness of information (Mellsop et al., 1982; Spitzer, 1983; Rubinson and Asnis, 1989; Kovess et al., 1992).

There are two types of instruments: rating scales and diagnostic interviews. There are substantial differences among the latter:

- Semi-structured standardized interviews and assessment procedures designed to be used by interviewers with clinical experience, of which the Current and Past Psychopathology Scales (CAPPS) (Endicott and Spitzer, 1972), the Present State Examination (PSE) (Wing et al., 1974), the

Schedules for Clinical Assessment in Neuropsychiatry (SCAN) (Wing et al., 1990; World Health Organization, 1995), the Schedule for Affective Disorders and Schizophrenia (SADS) (Endicott and Spitzer, 1978; Fyer et al., 1985), the Arbeitgemeineschaft fur Dokumentation in der Psychiatrie system (AMDP – Arbeitsgemeinschaft für Methodik und Dokumentation in der Psychiatrie, 2000), the Structured Clinical Interview for the Diagnostic and Statistic Manual of Mental Disorders (SCID) (Spitzer et al., 1992; First et al., 1997) are perhaps the best known. Although highly standardized and codified, most of these interviews maintain the structure of the typical clinical record. The interviewer is generally provided with standard wording of the question to be asked, but also encouraged to 'tailor' the interview procedure to the level of the subject's intelligence, education and clinical picture, for instance by rephrasing or adding questions or by asking subjects to describe symptoms in their own words. Moreover, clinical judgement is allowed in the sense that the subject's answers are not necessarily taken at face value and the interviewer can and should challenge possible inconsistencies in the subject's account and decide whether the requirements for the presence of a given symptom or criteria are met (Helzer, 1983; Spitzer, 1983; Spitzer et al. 1992). The different grades of severity of individual symptoms are often registered using rating scales and several anamnestic data (such as family history, physiological history, psychiatric history) are also usually recorded.

- Fully structured interviews primarily directed at epidemiological surveys, such as the Diagnostic Interview Schedule (DIS) (Robins et al., 1981), the Composite International Diagnostic Interview (CIDI) (World Health Organization, 1990) or the Revised Clinical Interview Schedule (CIS-R) (Lewis et al., 1992), where the main target is to identify cases who satisfy the precise diagnostic criteria required by the classification system(s) adopted (Weissman, 1988; Robins, 1990; De Girolamo, 1993). These interviews are usually administered by lay interviewers who are required to ask closed questions to which the subject responds with a simple 'yes' or 'no' answer; rephrasing questions is generally not allowed and there is no clinical judgement (Spitzer, 1983). Symptoms are usually assessed as present/absent without grading their severity.

However, none of the previously published assessment instruments was fully suited for our project. Non-clinical epidemiological instruments had some limitations and restrictions. The simple dichotomy of symptoms as present/absent, for instance, reduces the amount of information, given that almost all psychopathological phenomena may be graded along different levels of severity (Grove et al., 1981). These instruments are calibrated around a given diagnostic system (Robins, 1989), whereas we also aimed to explore the nosology of mental illness.

Moreover, currently available interviews for epidemiological surveys, either clinician- or lay-administered, do not cover some psychopathological conditions that are believed to be highly prevalent and to constitute a major public health issue, such as sleep disorders or some somatoform disorders (Wittchen, 2000). Finally, diagnostic interviews alone lack some items of information that we considered crucial, because the assessment of life events, costs of the illness, personality traits and history of previous treatments are either absent or insufficiently investigated in most of the published instruments. In fact, it is usual in clinical research to administer a diagnostic interview together with other assessment tools such as rating scales and instruments for the evaluation of personality traits, social adjustment, and life events. Such a highly detailed approach, however, is too lengthy, tiring and expensive for community-based research, thus suggesting the utility of combining the assessment of these different sets of data into a single instrument.

Simply, present interviews aim either to explore 'how' in clinical samples or to find 'how much' in the community, whereas our goal was that of exploring 'how' in the general population. For these reasons we decided to propose a comprehensive instrument that could approximate the methods usually adopted in clinical settings for use in a community survey.

Two main lines of previous research and experience converged in the development of the FPI. On one hand, our clinical research programmes started several years ago using a protocol that included a clinical interview, the lifetime version of the SADS-L (Fyer et al., 1985), plus rating scales and other assessment tools

appropriate for the specific project. Since then, there have been continuous progressive refinements through studies on psychiatric measures (Faravelli, 1983; Faravelli et al., 1986a; Faravelli and Paterniti, 1994; Faravelli et al., 1996), additions of new items, combinations of other instruments and exclusion of redundant information. This led to the construction of a standard assessment instrument that was extensively used for years in our department as well as in other facilities. The data derived from it have been used for several clinical studies. On the other hand, previous epidemiological studies conducted in the general population have brought about the progressive refinement of the interviewing instruments administered by psychiatrists for community surveys (Faravelli et al., 1989; Faravelli et al., 1990; Faravelli et al., 1997).

The combination of these two lines of research led to the Florence Psychiatric Interview (FPI), a clinically derived instrument for use in community samples.

The Florence Psychiatric Interview: general principles

The FPI aims to collect the largest possible amount of information relevant to the psychopathological state of an individual. It attempts to explore the major biographical data (for example, childhood events, education, jobs, life events, marital history), family history, traits, social adaptation, as well as symptoms, social functioning, treatments received and costs of the illness during the pathological episodes. All the information necessary to make a diagnosis (symptoms, severity, duration, co-occurrence, impairment, and so forth) are provided, so the FPI may generate diagnoses according to several nosographies. This notwithstanding, the FPI has the structure of a clinical record rather than that of a diagnostic interview and the diagnoses are to be seen as by-products.

The FPI has been designed to approximate the common anamnestic procedures that clinical psychiatrists use in their everyday practice. We have attempted, whenever possible, to use procedures already validated and published. In particular, as far as symptoms are concerned, we initially used a broad series of published rating scales covering almost all the aspects of psychopathology, including the Hamilton Rating Scale for Depression (Hamilton, 1960a), the Hamilton Rating Scale for Anxiety (Hamilton, 1960b), the Acute Panic Inventory (API) (Dillon et al., 1987), the Marks-Sheehan Phobia Scale (Sheehan, 1983), the Positive and Negative Syndrome Scale (PANSS) (Kay et al., 1987) the Yale-Brown Obsessive Compulsive Scale (Y-BOCS) (Goodman et al., 1989), the Agoraphobia Scale (Faravelli and Paterniti, 1994) and the Beigel-Murphy Manic-State Rating Scale (Beigel et al., 1971) and others (variable according to the specific project). After using this protocol extensively in clinical settings, we tried to reduce the number of items by eliminating those that were clearly redundant. In practice only one of those items with a reciprocal correlation higher than 0.80 and clearly exploring the same aspect was maintained. A few other symptoms not included in the above scales but taken into consideration by the major classification systems have been added.

The FPI is composed of a combination of different modules and has been designed for use in both clinical and non-clinical samples. The interview starts in an apparently informal way, exploring the chronology of the life of the subject and pinpointing the basic biographical events on a life chart. In this part, the occurrence of life events is elicited as well as their chronology. When the interviewer discovers a period in the subject's life with a possible psychopathology, a special form, called the 'episode' form, is opened and completed. The occurrence of symptoms, their duration and their severity are recorded on this. The events preceding the symptoms, the remedies adopted, the treatments received as well as the costs of the illness are explored and recorded. In the case of recurrent illness, as is often the case in psychiatry, the same inquiry is repeated for each separate episode. The pathological episode, therefore, is the basic module in collecting the information relative to the pathological history. The information that does not change during different episodes (sociodemographic data, family history, early life events, and so forth) is evaluated on a form entitled 'general'. Accordingly, the FPI consists of three sets of data:

- The life chart.
- The form entitled 'general'. This includes those variables that are normally evaluated once per subject: date of birth, sex, education, early life events (collected and evaluated as described earlier – Faravelli et al., 1986b), housing, family history, and so forth. This form also attempts to describe the

traits – those aspects of psychic/behavioural life – that are usually referred to as personality, axis II elements, temperament, and so forth. This section was added tentatively, because we were sceptical as to whether it would be possible to collect this set of data reliably.

- The form entitled 'episode'. This includes those aspects that are related to each pathological episode – symptoms, remedies, costs, events preceding the onset, and so forth. This form is designed to be completed a variable number of times, once for each psychopathological episode. An 'episode' is defined as any symptom, malaise, or worsening of functioning that interrupts the usual wellbeing or the usual course of the life of the subject. In order to qualify for separate pathological episodes, the inter-episodic period of wellbeing has to last for at least two months.

Unlike most other epidemiological interviews, where the lifetime occurrence of each symptom is explored, the FPI is primarily centred on the episode – first it attempts to isolate a period of illness and then it explores the aspects of that episode. It has the structure of a semi-structured interview: although all the questions are written, the interviewer is allowed a certain flexibility in order to tailor the interviewee's level. In most cases, including all the symptoms, the answers are codified into different grades of severity, with examples of each score given as anchoring points.

Description of the Florence Psychiatric Interview

Life chart

The FPI begins with a life chart (Roy-Byrne et al., 1985) designed to be completed in a descriptive and colloquial way, following a chronological order and including the basic biographical events – education, sentimental and work history, physical disturbances, and other major events (left side of the chart) – and the description of the occurrence and timing of the psychopathological episodes (right side of the chart). In order to elicit the presence of psychopathological episodes, *six* general, open-ended screening questions are asked. They cover the occurrence of anxiety, mood, eating, sexual or sleep disturbances, changes in performance or behaviour, physical symptoms not explained by medical conditions, use of alcohol or substances, use of psychotropic medications, or other medications such as off-the-counter, homeopathic or herbal products and vitamins. During this stage, the six general questions covering the interviewee's lifetime are asked at least once (for example, 'have your ever experienced a period when you felt upset, apathetic, sad or more anxious than usual?' or 'have you ever taken tranquilizers, sleeping pills, etc.?') and repeated at discretion of the interviewer at any time when a life change could justify the repetition of the question (for example, 'after being fired, did you feel upset, depressed, sad?'). When the interviewer, on the basis of the observation, suspects the presence of psychic problems, he is encouraged to insist and explore in detail the symptoms even if the interviewee answers negatively. Whenever a possible alteration from the normal course of life or the possible presence of psychological variations are detected, the interviewer goes into more precise details; an 'episode' form is opened and completed.

A list of the life events that must be assessed is provided; they are evaluated using a semi-structured procedure already described and employed by our group (Faravelli and Ambonetti, 1983; Faravelli and Pallanti, 1989).

The 'general' form

One 'general' form must be completed for each case. On its first pages it includes the usual sociodemographic data. It also contains the family history, a description of the subject's family during his or her childhood/adolescence, a description of the economic and social status and a description of the parents' rearing/upbringing patterns. The latter were obtained on the basis of items in the Parental Bonding Instrument (Parker et al., 1979). The early life events – those that occurred during the first 15 years of life – are recorded according to the method developed by our group (Faravelli et al., 1986b). In practice, the schedule takes into account the following events: death of parents, prolonged (greater than six months) and continuous separation from parents, divorce of parents, death of any cohabitant relative, severe illness of the child.

Data concerning schooling, including adaptation, performance and relationships, are included in the physiological history.

Page 3 is dedicated to the assessment of 29 traits. We included:

- the basic aspects of personality disorders as described in the DSM-IV;
- those symptoms listed by DSM-IV that may occur as mild and chronic, and which are usually interpreted as constituents of personality/temperament.

We have selected all those psychopathological aspects that can occur chronically, without taking into account any theoretical considerations about personality. In other words, traits do not necessarily correspond to personality disorders but are the simple registration of particular long-term psycho(patho)logical attributes. For each trait the scores range from 0 to 4, where 0 corresponds to the absence of the trait, 1 to its dubious presence, and 2 to its presence to a mild degree (not such as to be considered abnormal). A score of 3 is assigned to a trait of moderate severity (sometimes interferes negatively with the life of the subject) and the score of 4 is reserved for the greatest severity (it renders a normal life impossible and corresponds to the level of a chronic symptom).

For each trait the module includes its definition, the question(s) to ask the subject and the examples of typical behaviour corresponding to the different scores.

The 'episode' form

The initial section of this module comprises the data relative to the age of the subject at the moment of the onset of the episode, the type of onset, the duration of the episode, its course and outcome.

The second section of the 'episode' form focuses on the symptoms present during the episode and their severity. A total of 121 symptoms, which include the vast majority of those listed in the DSM-IV, are taken into account. Symptoms are considered independently of their diagnostic category, though they are listed according to their clinical homogeneity (symptoms relevant to sleep, eating, depression, mania . . .). For each symptom the overall criterion for assessing severity is as follows: a score of 0 reflects absence, 1 dubious presence, 2 mild, 3 moderate and 4 severe intensity. A score of 9 is reserved for symptoms that cannot be assessed. Whenever possible, the definition and the scoring systems of the symptoms have been taken or adapted from published and validated rating scales. For each symptom the form lists:

- its definition, either following the DSM-IV description or the original definition of the rating scale from which the item is derived;
- the DSM-IV categories where the symptom is listed among the diagnostic requirements;
- the question(s) to be used by the interviewer;
- the examples corresponding to each typical score of severity, used as anchor points.

An empty space allows the interviewer to write notes, in particular about possible differences in the duration of the symptom compared with the duration of the episode.

By default a symptom is considered present throughout the entire episode, unless otherwise specified. Severity refers to the maximum intensity of the symptom within that specific episode.

The third section of the form is for the steps taken by the subject in order to obtain relief from the disorder: health/therapeutic figures consulted and treatments received.

The last section is dedicated to the costs of the illness: working days lost, number of visits, number of medical tests, time spent by relatives in looking after the subject, percentage reduction in social and work activities.

Diagnostic algorithms

The possibility of fully automated diagnostic algorithms has been foreseen. The data are collected without reference to any specific diagnostic system, and the inquiry is broad enough to collect sufficient information for all the known diagnostic procedures, so the FPI is theoretically able to print out diagnoses according to several nosographic systems. At the moment the algorithm for DSM-IV has been implemented and tested.

Interviewers

The FPI is intended to be used by interviewers with some experience in psychiatry. In particular, three requirements are necessary:

- a basic knowledge of theoretical psychiatry at medical or psychological degree level (having passed the psychiatry examination at a faculty of medicine or psychology);
- at least one year of clinical experience in diagnosing and treating psychiatric patients (for example, as a resident);
- specific training and routine administration and use, during psychiatric work, of structured interviews and rating scales.

Psychometric properties

Apart from the usual validations that are common to all the measurements instruments (for example, inter-rater reliability, stability over time, comparison with other instruments), the FPI relies on some special assumptions that needed to be specifically tested. The FPI has therefore undergone a series of small validation studies, of which some have already been reported (Faravelli et al., 1998).

Inter-rater reliability

Fifteen psychiatric patients (seven males and eight women; age range 19–57), consecutively referred to our outpatient unit, were rated by two different interviewers during the same interview. Spearman's rho coefficients ranged from 0.73 to 1 for the symptoms, 0.72 to 1 for the traits, and 0.90 to 1 for the costs (Faravelli et al., 1998).

Test-retest

In order to test whether present pathology could influence the subject's answers, 15 psychiatric patients (six males and nine women, with an age range from 21 to 63) consecutively referred to our outpatient unit were evaluated by an interviewer during the acute stage of their illness and re-evaluated by a different interviewer, blind to the first evaluation, two to six months later, when their pathology had remitted. Table 1 shows the results.

Table 1: Test–retest : 15 psychiatric cases assessed during the acute stage of their illness and after remission

	Number of comparisons	Spearman's rho	Cohen's kappa	p
Number of episodes	15	1.00		0.000
Presence of early life events	15		1.00	0.000
Positive family history	15		1.00	0.000
SOCIAL ADAPTATION				
Family	15	0.95		0.004
Extended family	15	1.00		0.000
Sentimental	15	0.98		0.000
Work	15	0.99		0.000
Social activities	15	0.97		0.000
TRAITS				
Sociable	15	1.00		0.000
Secure	15	1.00		0.000
Anxiety	15	1.00		0.000
Depression	15	0.96		0.000
Insomnia	15	0.89		0.000
Hypersomnia	15	0.52		0.082
Hyperphagia	15	1.00		0.000
Hyporexia	15	0.82		0.000
Indecisiveness	15	1.00		0.000
Irritability	15	1.00		0.000
Aggression	15	*		
Kleptomania	15	*		
Trichotillomania	15	1.00		0.000
Affective instability	15	1.00		0.000
Chronic feelings of emptiness	15	0.64		0.000
Impulsivity	15	0.97		0.000
Identity disturbance	15	1.00		0.000
Addictive behaviours	15	0.96		0.000
Dependent	15	0.80		0.001

Continued

Obsessive	15	1.00		0.000
Avoidant	15	1.00		0.000
EPISODE				
Duration (weeks)	22	1.00		0.000
Outcome	22		0.87	0.000
Presence of life events in the 12 months preceding episode	22		1.00	0.000
Number of working days lost by patient	20	0.98		
Number of working days lost by relatives	22	1.00		
Hours/day lost by relatives in caring for patient	22	0.95		
Number of medical tests	22	0.98		
Percentage reduction in working activities	22	1.00		
Percentage reduction in pleasurable activities	22	0.98		
Percentage reduction in social activities	22	0.99		
SYMPTOMS				
Insomnia (initial)	22	0.88		0.000
Insomnia (terminal)	22	0.94		0.000
Hypersomnia	22	0.97		0.000
Non-restorative sleep	22	0.89		0.000
Circadian rhythm sleep disorder	22	0.80	.	0.000
Nightmares	22	0.88		0.000
Hyporexia	22	0.90		0.000
Weight loss	22	0.88		0.000
Depressed mood	22	0.83		0.000
Anhedonia	22	0.92		0.000
Suicidality	22	0.88		0.000
Feelings of worthlessness	22	0.98		0.000
Excessive or inappropriate guilt	22	0.98		0.000
Agitation	22	0.98		0.000
Psychomotor retardation	22	0.79		0.000
Diminished ability to think or concentrate	22	0.85		0.000
Leaden paralysis	22	0.85		0.000
Fatigue or loss of energy	22	0.83		0.000
Indecisiveness	22	0.86		0.000
Depression regularly worse in the morning	22	0.93		0.000
Lack of reactivity to usually pleasurable stimuli	22	0.89		0.000
Apathia	22	0.71		0.006
Affective flattening	22	0.81		0.001
Abulia	22	0.90		0.000
Simple phobias	22	1.00		0.000
Agoraphobia	22	0.98		0.002
Social phobia	22	1.00		0.000
Panic attacks	22	0.80		0.000
Palpitations or accelerated heart rate	22	0.80		0.000
Sweating	22	0.82		0.000
Anticipatory anxiety	22	0.88		0.000
Generalized anxiety	22	0.99		0.000
Obsessions	22	1.00		0.000
Compulsions	22	1.00		0.000
Loss of desire for sexual activities	22	0.96		0.000
Gastrointestinal symptoms	22	1.00		0.000
Hypochondriasis	22	1.00		0.000

Residents versus experienced psychiatrists

The main advantage of a semi-structured interview administered by an experienced psychiatrist should be a deeper diagnostic sensitivity, increasing validity without losing reproducibility (Brugha et al., 1999). In our case, we had to discover whether trainees with a good background of everyday clinical practice and research would be comparable to experienced psychiatrists. For this purpose 15 subjects drawn from a non-clinical sample (hospital employees, six males and nine females; age range 23–58) and 25 consecutively referred psychiatric patients (10 outpatients and 15

Table 2: Inter-rater agreement: fully qualified psychiatrist versus resident (N = 38)

	Symptoms rated 0–4		Symptoms rated present/absent
	Percentage agreement	Spearman's rho	Cohen's kappa
Insomnia (initial)	87.9	0.96	0.79
Insomnia (central)	97.0	0.97	0.94
Insomnia (terminal)	97.0	0.92	0.90
Binge eating	97.0	0.99	0.93
Hyporexia	97.0	0.99	0.93
Weight loss	97.0	0.94	0.93
Fear of gaining weight	100.0	1.00	1.00
Weight gain	93.9	0.99	0.87
Depressed mood	78.8	0.89	0.68
Anhedonia	78.8	0.78	0.70
Suicidality	90.9	0.80	0.83
Feelings of worthlessness	75.8	0.78	0.62
Excessive or inappropriate guilt	84.8	0.78	0.74
Psychomotor agitation	93.9	0.99	0.90
Psychomotor retardation	87.9	0.71	0.73
Diminished ability to think or concentrate	81.8	0.91	0.72
Leaden paralysis	97.0	0.99	0.93
Fatigue or loss of energy	84.8	0.96	0.79
Indecisiveness	78.8	0.95	0.66
Depression regularly worse in the morning	97.0	0.88	0.94
Lack of reactivity to usually pleasurable stimuli	93.9	0.98	0.88
Apathia	84.8	0.86	0.70
Affective flattening	97.0	0.98	0.92
Abulia	87.9	0.95	0.69
Elevated mood	97.0	1.00	0.49
Irritable mood	87.9	0.93	0.77
Increase in goal-directed activity	93.9	0.89	0.76
Excessive involvement in pleasurable activities	97.0	1.00	0.49
Simple phobias	100.0	1.00	1.00
Social phobia	100.0	1.00	1.00
Panic attacks	97.0	0.98	0.91
Anticipatory anxiety	97.0	0.73	0.79
Generalized anxiety	93.9	0.96	0.91
Obsessions	97.0	0.99	0.92
Compulsions	100.0	1.00	1.00
Loss of desire for sexual activities	93.9	0.99	0.91
Delusions (mood congruent)	100.0	1.00	1.00
Organised delusions	100.0	1.00	1.00
Suspiciousness	100.0	1.00	1.00
Aggression	100.0	1.00	1.00

inpatients, 11 males and 14 females, age range 22–61) were evaluated separately by a qualified and experienced psychiatrist and then by a resident on two different occasions using the FPI, both unaware of the results of the other. Correlations are summarized in Table 2.

Ability to retrieve lifetime symptoms

As previously stated, the FPI attempts to isolate a pathological episode and then explores its characteristics. This process differs considerably from the usual one of exploring the lifetime occurrence of each single symptom, and it therefore needs verification. To do this, two different interviewers administered the FPI and the CIDI on two different occasions with 30 psychiatric patients (11 males and 19 women; age range 18–63) consecutively referred to our outpatient unit. All the symptoms emerging during the various episodes at the FPI were transformed into a measure of lifetime presence/absence and were compared with those elicited by the CIDI (Table 3). Overall, agreement was satisfactory (the kappa values that were below the level of significance were mainly due to the small frequency of positive cases of the item in question).

Table 3: Comparison between FPI and CIDI (lifetime presence of symptoms, N = 30)

	Percentage agreement	Kappa	P*
SYMPTOMS			
Insomnia (initial)	63.4	0.30	0.06
Insomnia (central)	73.3	0.47	0.007
Insomnia (terminal)	83.3	0.67	0.00025
Hyperphagia	83.3	0.19	0.28
Hyporexia	83.4	0.67	0.0001
Weight loss	70.0	0.41	0.01
Fear of gaining weight	90.0	0.61	0.00077
Binge eating	90.0	0.36	0.0095
Body image disturbance	96.7	0.78	0.00001
Amenorrhea	100.0	1.00	0.00
Dieting or fasting	93.4	0.63	0.00019
Depressed mood	90.0	0.76	0.00002
Anhedonia	90.0	0.80	0.00001
Suicidality	80.0	0.60	0.00091
Feelings of worthlessness	86.6	0.68	0.00015
Excessive or inappropriate guilt	73.3	0.47	0.0099
Psychomotor agitation	70.0	0.31	0.076
Psychomotor retardation	75.6	0.53	0.002
Diminished ability to think or concentrate	96.7	0.92	0.00
Fatigue or loss of energy	86.6	0.72	0.00008
Indecisiveness	83.3	0.66	0.00011
Depression regularly worse in the morning	83.4	0.66	0.00019
Lack of reactivity to usually pleasurable stimuli	80.0	0.60	0.00091
Elevated mood	96.6	0.86	0.00
Irritable mood	80.0	0.51	0.0129
Inflated self-esteem or grandiosity	86.7	0.53	0.00093
Decreased need for sleep	93.3	0.76	0.00003
Distractibility	83.3	0.44	0.01431
Psychomotor agitation	83.4	0.55	0.0022
Excessive involvement in pleasurable activities	86.7	0.52	0.0044
Flight of ideas	93.6	0.86	0.00
Simple phobias	76.6	0.13	0.356
Agoraphobia	86.7	0.63	0.00018
Social phobia	93.3	0.76	0.00004

Continued

Table 3: Continued

	Percentage agreement	Kappa	P*
SYMPTOMS			
Panic attacks	90.0	0.73	0.00003
Palpitations or accelerated heart rate	90.0	0.73	0.0001
Sweating	96.7	0.88	0.00
Trembling or shaking	96.6	0.86	0.00
Feelings of shortness of breath or smothering	96.7	0.88	0.00
Feelings of choking	96.7	0.90	0.00
Nausea or abdominal distress	100.0	1.00	0.00
Feeling dizzy, unsteady, lightheaded or faint	83.3	0.44	0.01431
Derealization or depersonalization	96.7	0.88	0.00
Fear of losing control or going crazy	100.0	1.00	0.00
Fear of dying	100.0	1.00	0.00
Paresthesias	96.7	0.88	0.00
Chills or hot flushes	100.0	1.00	0.00
Anticipatory anxiety	86.7	0.53	0.00093
Generalized anxiety	76.7	0.54	0.00267
Restlessness or feeling keyed up or on edge	66.7	0.14	0.41
Easily fatigued	73.3	0.32	0.016
Difficulty concentrating or mind going blank	80.0	0.55	0.00222
Irritability	73.4	0.19	0.257
Muscle tension	80.0	0.33	0.0152
Pollachiuria	86.6	0.26	0.15
Obsessions	93.3	0.71	0.00004
Compulsions	90.0	0.67	0.00024
Loss of desire for sexual activities	83.3	0.59	0.0011
Somatoform symptoms	63.3	0.22	0.216
Pain symptoms	80.0	0.28	0.107
Gastrointestinal symptoms	83.3	0.44	0.014
Pseudoneurological symptoms	83.3	0.51	0.005
Conversion symptoms	86.6	0.26	0.11
Delusions	100.0	1.00	0.00
Hallucinations	93.3	0.71	0.0001
Substance dependence	93.3	0.71	0.0001

* probability computed with chi square, using Yates's correction when necessary

Recall bias

Fully structured interviews take into account symptoms throughout the subjects' entire lives, whereas most of the clinical interviews only consider recent periods. The reasoning behind this is that bias due to recall could negatively condition the response. It has been reported, in fact, that recall bias may seriously influence the reliability of retrospective inquiries. On the other hand, other authors contend that retest may yield appreciable reproducibility even at long distance (Wittchen et al., 1989). The fact, however, that the main epidemiological surveys also explore the lifetime prevalence of psychiatric symptoms, illustrates the potential value of retrieving information from the past.

In order to explore this issue, 32 outpatients (13 males and 19 women; age range 25–54) for whom we had previous documentation, were interviewed regarding the symptoms experienced two to 12 years earlier (median = 4.2 years), when they were first examined with the same scales used in the FPI. Table 4 summarizes the results, showing that in most cases psychiatric symptoms are generally fairly well remembered even several years later. It was found that the main symptoms are generally retained and the information is

Table 4: Recall bias: 32 cases reinterviewed 2–12 years later (mean 5.2, median 4.2 years). Results have been analysed considering the symptoms scored 0 to 4 (columns 2, 3) and present/absent (columns 4, 5)

	Symptoms scored 0–4		Symptoms scored 0–1 (absent–present)	
	Percentage agreement	Spearman's rho	Percentage agreement	Cohen's kappa
Indecisiveness	80.8	0.67	88.5	0.06
Psychomotor retardation	96.2	0.68	100.0	1.00
Depressed mood	61.5	0.71	92.3	0.82
Psychomotor agitation	50.0	0.70	80.8	0.53
Insomnia (initial)	65.4	0.73	80.8	0.62
Insomnia (terminal)	50.0	0.51	69.2	0.39
Depression regularly worse in the morning	76.9	0.57	80.8	0.56
Anhedonia	88.5	0.86	92.3	0.84
Weight loss	61.5	0.62	76.9	0.46
Weight gain	96.0	0.72	100.0	1.00
Excessive or inappropriate guilt	88.5	0.79	92.3	0.62
Suicidality	84.6	0.61	92.3	70.50
Somatoform symptoms	84.6	0.71	84.6	0.57
Fatigue or loss of energy	76.9	0.56	84.6	0.51
Suspiciousness	100.0	1.00	100.0	1.00
Delusions	96.2	0.89	96.2	0.78
Hallucinations	100.0	1.00	100.0	1.00
Disorganized thought	100.0	0.56	100.0	1.00
Social withdrawal	100.0	1.00	100.0	1.00
Elevated mood	96.2		100.0	1.00
Aggression	96.2	0.74	96.2	0.78
Impulse dyscontrol	96.2	0.99	100.0	1.00
Excessive involvement in pleasurable activities	96.2		100.0	1.00
Obsessions	96.2	0.89	96.2	0.83
Compulsions	92.3	0.85	96.2	0.78
Simple phobias	84.6	0.75	88.5	0.52
Hypochondriasis	92.3	0.88	100.0	1.00
Generalized anxiety	76.9	0.92	96.2	0.92
Muscle tension	76.9	0.86	88.5	0.76
Panic attacks	76.9	0.98	100.0	1.00
Agoraphobia	92.3	0.96	100.0	1.00
Loss of desire for sexual activities	96.2	0.99	100.0	1.00

usually sufficient to repeat the same diagnosis. The diagnostic algorithm applied to the symptoms recalled reproduced the original main diagnosis in 94% of the cases.

Ability to produce DSM-IV diagnoses

The concurrent validity of the FPI has also been studied using the SCID as the standard reference instrument. We have adopted the SCID I/P version (First et al., 1995). Seventeen patients (13 outpatients and four inpatients, seven males and 10 females; age range 18–66) and 50 subjects drawn from a community probability sample (21 males and 29 females; age range 16–62) have been interviewed with both the SCID and the FPI on two separate occasions. In 33 cases the SCID was administered first and the FPI second, and vice versa for the remaining 34 cases. The same interviewer administered both the interviews at three- to five-day intervals.

Agreement relative to lifetime diagnosis was studied. The two instruments were in perfect agreement in assessing the absence of psychiatric disorders (those with negative results on the SCID were also negative on the FPI). Among those with at least one psychiatric disorder, the FPI could reproduce all the diagnoses elicited by the SCID. Moreover, the FPI provided

three further diagnoses: in one case depression n.o.s. and anxiety n.o.s., in another anxiety n.o.s. and in one case generalized anxiety disorder. Furthermore, the FPI also diagnosed one case of gambling and one case of onycophagia, categories that are not taken into account by the SCID.

In the 30 psychiatric cases cited above where both the FPI and the CIDI were used, agreement was slightly lower: two cases detected by the CIDI as having major depression were classified as depression n.o.s. by the FPI and one case of social phobia at the CIDI was ignored by the FPI. Moreover, in four cases the CIDI produced a diagnosis of alcohol abuse that the FPI failed to detect. For the remaining 56 lifetime diagnoses the two instruments were in agreement.

Construct validity

The more an instrument is able to verify predictions the more it approximates reality. In our case the prediction is that results (diagnoses) obtained by the FPI will be consistent with all the clinical expectations about that diagnosis. We have adopted this principle in three ways.

- Comparison with clinical judgements for discordant diagnoses. In four cases out of the 30 investigated the CIDI produced a diagnosis of alcohol abuse that the FPI failed to detect. Further careful clinical investigations conducted by the treating psychiatrists, which also used laboratory tests (alcohol blood levels), were consistent in concluding that in none of these cases a clinical diagnosis of alcohol dependence/ abuse was applicable.
- Social phobia. The FPI was used for a community study. In this study 76 subjects were found to be suffering from social phobia. All these subjects were further contacted and re-interviewed using a detailed inquiry specific for social phobia. In all the cases the original diagnosis was confirmed (Faravelli et al , 2000).
- Eating disorders. The same procedure was used for those subjects (N = 26) for whom the FPI had elicited a diagnosis of eating disorder. These subjects were administered the Eating Disorders Examination (Fairburn and Cooper, 1993), which confirmed the original diagnoses (Zucchi et al., 2001).

Feasibility

The FPI was employed in a community study where more than 800 subjects were interviewed. It was well accepted both by the residents, who felt at ease with its clinical shape, and by the subjects, and seemed to like its colloquial way, lack of repetitions and absence of insistence in fields where there was no need to explore further what was already established.

The time required for an interview varies, depending on the number of psychopathological episodes for which it is necessary to fill in an episode form. The average time for administering the two forms that are always completed (form general and life chart) is around 30 minutes, whereas the administration of each episode form may require 10 to 20 minutes. Overall, administration seems to be similar to that of the SCAN when employed in community samples (Brugha et al., 2001).

Compared to other instruments, such as the CIDI, the FPI is generally shorter to administer. In the more than 700 interviews conducted up to now it has always been possible to complete the procedure in a single step whereas, in our experience with the CIDI it has been necessary to stop interviewing and resume on a different occasion in more than 50% of cases.

Comment and conclusion

Historically, the samples observed by psychiatrists have continuously broadened, from the patients of mental hospitals, to the inpatients of general hospitals, to outpatients. This notwithstanding, psychiatric samples are still likely to be far from satisfactory representations of psychopathology. We felt, therefore, that it would be of interest to repeat the observations so far conducted on psychiatric samples on subjects drawn from the general population. The FPI was conceived in this framework, with the purpose of describing the clinical characteristics of the subjects suffering from psychiatric disorders, including those who never contact a psychiatrist. Its main aim, therefore, is to compare psychiatric samples and community samples in terms of clinical characteristics, rather than to reproduce prevalence studies. The FPI is thus a collection of usual research methods. The advantage over the use of single instruments is its homogeneity and, most of all, in the abolition of repetitions and redundancies. In non-clinical samples, in fact, the interviewees are expected to be less available than in clinical samples, where the

patient can be examined several times in different days. We tried, therefore, to collect as much information as possible in a single interviewing session, including reports of the past pathological history. The clinical instruments are mainly devised to assess the present state, so we attempted to also use them retrospectively and therefore chose to look at episodes.

Given the origin of the FPI, it is no surprise that the data on reliability reflect those usually reported for other clinical assessment instruments

Although they are preliminary and limited in number, our findings also showed that by looking at episodes one is able to retrieve approximately the same amount of lifetime information as one can with an interview, such as the CIDI, designed to take the lifetime approach. The advantage of episode-based procedure is mainly that of detecting well-delimited periods of illness, which is necessary in order to explore factors such as triggers and costs.

We are aware that our findings come from an homogeneous group of psychiatrists and psychiatric residents and should be validated in more heterogeneous groups. However, as almost all the items belong to internationally known rating scales, we are confident that simple agreement tests conducted on videotapes, as is usual in pharmacological trials, should provide sufficient reliability even in different contexts.

The present diagnostic interviews are able to detect disorders according to one diagnostic system (two in the case of the CIDI). Now, on one hand, nosography is a continuously developing issue; on the other hand there is currently serious dissatisfaction toward the classifications of mental disorders of today (Van Praag et al., 1987; Goldberg, 1996; Van Praag, 1997; Angst et al., 2001). The FPI was built without relying on any pre-defined classifications and one of its goals is to collect ample sets of data to test, verify and hypothesize different proposal for classifying cases.

It is worth repeating that the FPI is meant to explore the basic psychiatric elements in a naturalistic unbiased sample, with the prospect of verifying the 'how' rather than the 'how much', and this is the basic difference between this instrument and typically diagnostic interviews.

Its use with community samples is feasible, in our experience, and could produce results comparable with those of the investigations carried out in clinical samples using common clinical research procedures.

We are aware that the cost of an epidemiological survey conducted by psychiatrists would be unsustainable for most groups, but the FPI is intended for purposes other than massive surveys. It could probably be used as a complement to larger epidemiological inquiries. Moreover we found that giving interviews in the community could be very effective training for the residents.

The ability of the psychiatric patient to reliably recall his past state seems to depend more on the levels of accuracy required than on the absolute capacity of the patient to recall. Even though it was not possible to obtain the same level of accuracy as a present state examination, we found that a non-trivial amount of reliable information is generally retrievable, even retrospectively. The FPI, however, lends itself to the prospective evaluation of specific cohorts, in the same way as the Zurich and Munich studies (Angst et al., 1984; Wittchen et al., 1992). Our preliminary experience with it employed a two-stage design, using the FPI to interview the cases already screened by the GP (to be published).

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