# Psychiatric assessment and diagnosis

# 1

The psychiatric assessment is different from a medical or surgical assessment in that: (1) the history taking is often longer and requires understanding each patient's unique background and environment; (2) a mental state examination (MSE) is performed; and (3) the assessment can in itself be therapeutic. Fig. 1.1 provides an outline of the psychiatric assessment, which includes a psychiatric history, MSE, risk assessment, physical examination and formulation.

## INTERVIEW TECHNIQUE

- Whenever possible, patients should be interviewed in settings where privacy can be ensured – a patient who is distressed will be more at ease in a quiet office than in an accident and emergency cubicle.
- Chairs should be at the same level and arranged at an angle, so that you are not sitting directly opposite the patient.
- Establishing rapport is an immediate priority and requires the display of empathy and sensitivity by the interviewer.
- Notes may be taken during the interview; however, explain to patients that you will be doing so. Make sure that you still maintain good eye contact.
- Ensure that both you and the patient have an unobstructed exit should it be required.
- Carry a personal alarm and/or know where the alarm in the consulting room is, and check you know how to work the alarms.
- Introduce yourself to the patient and ask them how they would like to be addressed. Explain how long the interview will last. In examination situations, it may

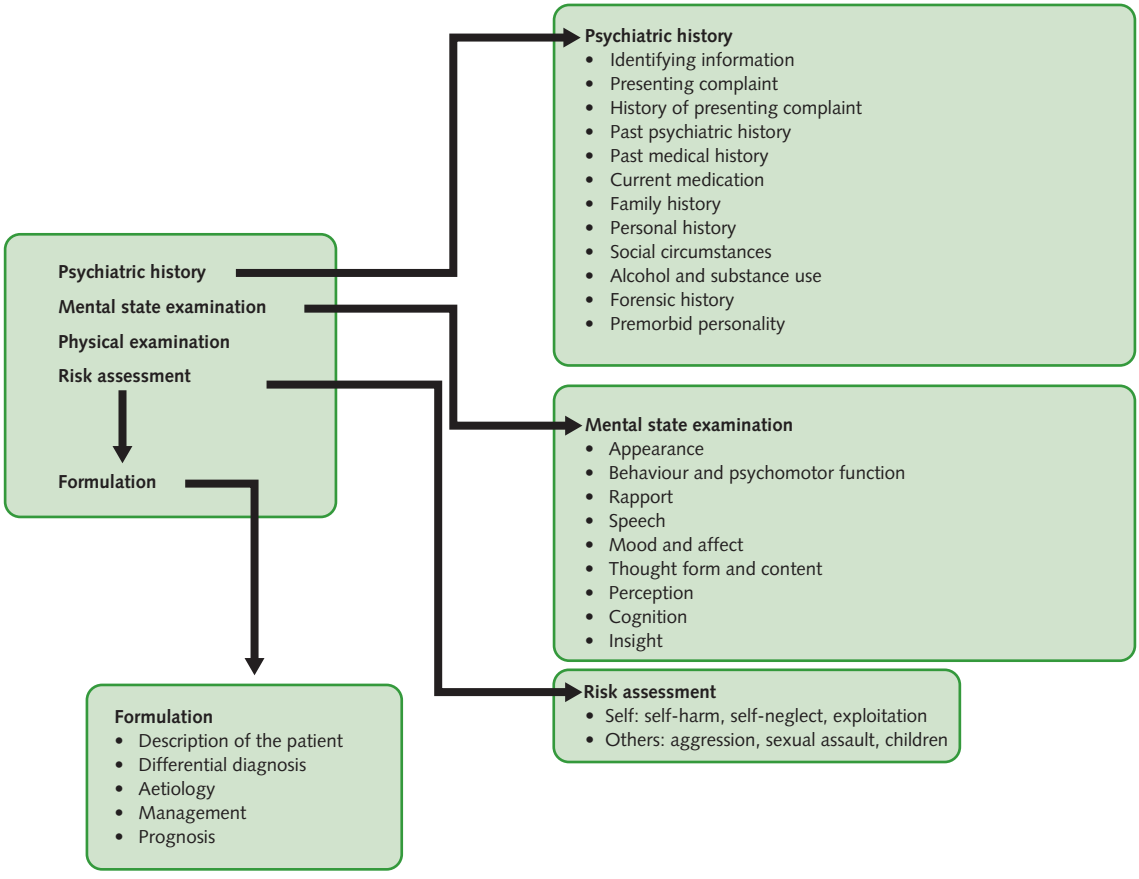


**Fig. 1.1** Outline of the psychiatric assessment procedure.

prove helpful to explain to patients that you may need to interrupt them due to time constraints.
- Keep track of and ration your time appropriately.
- Flexibility is essential (e.g. it may be helpful to put a very anxious patient at ease by talking about their background before focusing in on the presenting complaint).

**HINTS AND TIPS**

Arrange the seating comfortably, and in a way that allows everyone a clear exit, before inviting the patient into the room.

Make use of both open and closed questions when appropriate:

*Closed questions* limit the scope of the response to one- or two-word answers. They are used to gain specific information and can be used to control the length of the interview when patients are being over-inclusive. For example:

- Do you feel low in mood? (Yes or no answer)
- What time do you wake up in the morning? (Specific answer)

Note that closed questions can be used at the very beginning of the interview, as they are easier to answer and help to put patients at ease (e.g. 'Do you live locally?'; 'Are you married?'; see Identifying information later).

*Open questions* encourage the patient to answer freely with a wide range of responses and should be used to elicit the presenting complaint, as well as feelings and attitudes. For example:

- How have you been feeling lately?
- What has caused you to feel this way?

**COMMUNICATION**

Rapport building is vital when working in mental health. Always think why a patient may have difficulty establishing one with you (e.g. persecutory delusions, withdrawal, apathy). Failure to establish rapport should never be due to the interviewer.

# PSYCHIATRIC HISTORY

The order in which you take the history is not as important as being systematic, making sure you cover all the essential subsections. A typical format for taking a psychiatric history is outlined in Fig. 1.1 and is described in detail below.

## Identifying information

- Name
- Age
- Marital status and children
- Occupation
- Reason for the patient's presence in a psychiatric setting (e.g. referral to out-patient clinic by family doctor, admitted to ward informally having presented at casualty)
- Legal status (i.e. if detained under mental health legislation)

For example:

*Mrs LM is a 32-year-old married housewife with two children aged 4 and 6 years. She was referred by her family doctor to a psychiatric out-patient clinic.*

## Presenting complaint

Open questions are used to elicit the presenting complaint. Whenever possible, record the main problems in the patient's own words, in one or two sentences, instead of using technical psychiatric terms. For example:

*Mrs LM complains of 'feeling as though I don't know who I am, like I'm living in an empty shell'.*

Patients frequently have more than one complaint, some of which may be related. It is helpful to organize multiple presenting complaints into groups of symptoms that are related; for instance, 'low mood', 'poor concentration' and 'lack of energy' are common features of depression. For example:

*Mrs LM complains firstly of 'low mood', 'difficulty sleeping' and 'poor self-esteem', and secondly of 'taking to the bottle' associated with withdrawal symptoms of 'shaking, sweating and jitteriness' in the morning.*

It is not always easy to organize patients' difficulties into a simple presenting complaint in psychiatry. In this case, give the chief complaint(s) as the presenting complaint, and cover the rest of the symptoms or problems in the history of the presenting complaint.

## History of presenting complaint

This section is concerned with eliciting the nature and development of each of the presenting complaints. The following headings may be helpful in structuring your questioning:

- *Duration:* when did the problems start?
- *Development*: how did the problems develop?
- *Mode of onset:* suddenly, or over a period of time?
- *Course:* are symptoms constant, progressively worsening or intermittent?
- *Severity:* how much is the patient suffering? To what extent are symptoms affecting the patient's social and occupational functioning?
- *Associated symptoms:* certain complaints are associated with clusters of other symptoms that should be enquired about if patients do not mention them spontaneously. This is the same approach as in other

**Table 1.1** Typical questions used to elicit specific psychiatric symptoms

| Questions used to elicit… | Chapter |
|---|---|
| Suicidal ideas | 6 |
| Depressive symptoms | 11 |
| Mania/hypomania | 10 |
| Delusions | 9 |
| Hallucinations | 9 |
| Symptoms of anxiety | 12 |
| Dissociative symptoms | 14 |
| Obsessions and compulsions | 13 |
| Somatoform disorders | 15 |
| Memory and cognition | 7 |
| Problem drinking | 8 |
| Symptoms of anorexia and bulimia | 16 |
| Symptoms of insomnia | 25 |

specialties; for example, enquiring about nausea, diarrhoea and distension when someone reports abdominal pain. When 'feeling low' is a presenting complaint, biological, cognitive and psychotic features of depression, as well as suicidal ideation, should be asked about. You can also ask about symptom clusters for psychosis, anxiety, eating problems, substance use and cognitive problems, among others. Also, certain symptoms are common to many psychiatric conditions, and these should be screened for (e.g. a primary complaint of insomnia may be a sign of depression, mania, psychosis or a primary sleep disorder).

- *Precipitating factors:* psychosocial stress frequently precipitates episodes of mental illness (e.g. bereavement, moving house and relationship difficulties).

Table 1.1 directs you to the relevant chapters with example questions for different components of the history and MSE.

**HINTS AND TIPS**

It is useful to learn how to screen patients for common symptoms. This is especially so with patients who are less forthcoming with their complaints. Remember to ask about:

- Low mood (depression)
- Elevated mood and increased energy (hypomania and mania)
- Delusions and hallucinations (psychosis)
- Free-floating anxiety, panic attacks or phobias (anxiety disorders)
- Obsessions or compulsions (obsessive-compulsive disorder)
- Alcohol or substance abuse

**HINTS AND TIPS**

Depression and obsessive-compulsive symptoms often coexist (>20%), with onset of obsessive-compulsive symptoms occurring before, simultaneously with or after the onset of depression. You may find it useful to have a set of screening questions ready to use.

## Past psychiatric history

This is an extremely important section, as it may provide clues to the patient's current diagnosis. It should include:

- Previous or ongoing psychiatric diagnoses
- Dates and duration of previous mental illness episodes
- Previous treatments, including medication, psychotherapy and electroconvulsive therapy
- Previous contact with psychiatric services (e.g. referrals, admissions)
- Previous assessment or treatment under mental health legislation
- History of self-harm, suicidal ideas or acts

## Past medical history

Enquire about medical illnesses or surgical procedures. Past head injury or surgery, neurological conditions (e.g. epilepsy) and endocrine abnormalities (e.g. thyroid problems) are especially relevant to psychiatry.

## Current medication

Note all the medication patients are using, including psychiatric, nonpsychiatric and over-the-counter drugs. Also enquire how long patients have been on specific medication and whether it has been effective. Nonconcordance, as well as reactions and allergies, should be recorded.

## Family history

- Enquire about the presence of psychiatric illness (including suicide and substance abuse) in family members, remembering that genetic factors are

implicated in the aetiology of many psychiatric conditions. A family tree may be useful to summarize information.
- Enquire whether parents are still alive and, if not, causes of death. Also ask about significant physical illnesses in the family.
- Ask whether the patient has any siblings and, if so, where they are in the birth order.
- Enquire about the quality of the patient's relationships with close family members.

## Personal history

The personal history consists of a brief description of the patient's life. Time constraints will not allow an exhaustive biographical account, but you should attempt to include significant events, perhaps under the following useful headings:

### Infancy and early childhood (until age 5 years)

- Pregnancy and birth complications (e.g. prematurity, foetal distress, caesarean section)
- Developmental milestones (e.g. age of crawling, walking, speaking, bladder and bowel control)
- Childhood illnesses
- Unusually aggressive behaviour or impaired social interaction

### Later childhood and adolescence (until completion of higher education)

- History of physical, sexual or emotional abuse
- School record (e.g. academic performance, number and type of schools attended, age on leaving, final qualifications)
- Relationships with parents, teachers and peers. Victim or perpetrator of bullying
- Behavioural problems, including antisocial behaviour, drug use or truancy
- Higher education and training

### Occupational record

- Details of types and duration of jobs
- Details of and reasons for unemployment and/or dismissal

### Relationship, marital and sexual history

- Puberty: significant early relationships and experiences, as well as sexual orientation
- Details and duration of significant relationships Reasons for break-ups
- Marriage/divorce details. Children.
- Ability to engage in satisfactory sexual relationships. Sexual dysfunction, fetishes or gender identity problems (only enquire if problem is suspected).

**COMMUNICATION**

A history of childhood abuse is important to detect, but it can feel awkward to ask about. Most people respond well to being straightforwardly asked 'Would you say you were ever abused in any way when you were growing up?' In young people, or those you are struggling to build a rapport with, a more graded approach may be preferable (e.g. 'When was your first relationship? When was your first sexual experience? Have you ever had an unpleasant sexual experience? Sometimes such experiences are unpleasant because they are unwanted or because the person is too young to understand …?') Leaving the question open allows the patient room to answer freely, rather than simply answering 'yes' or 'no'.

## Social circumstances

This includes accommodation, social supports and relationships, employment and financial circumstances and hobbies or leisure activities. It is important to identify if the patient has current frequent contact with children, in case their presentation raises any child protection concerns.

## Alcohol and substance use

This section should never be overlooked, as alcohol/substance-related psychiatric conditions are very common.

The CAGE questionnaire (see Chapter 8) is a useful tool to screen for alcohol dependence. If a patient answers affirmatively to two or more questions, regard the screen as positive and go on to check if they meet criteria for alcohol dependence syndrome (see Chapter 8). Try to elicit a patient's typical drinking day, including daily intake of alcohol in units, type of alcohol used, time of first drink of the day and places where drinking occurs (e.g. at home alone or in a pub).

If recreational drugs have been or are being used, record the drug names, routes of administration (intravenous, inhaled, oral ingestion) and the years and frequency of use. Also enquire about possible dependence (Chapter 8).

## Forensic history

Enquire about the details and dates of previous offences and antisocial behaviour, including prosecutions, convictions and prison sentences. It is important to ask specifically about violent crime, the age of the patient's first violent offence and whether the patient has any charges pending. Pending charges may be a source of stress for the patient, and in some cases a reason to report mental health symptoms with a view to secondary gain.

## Premorbid personality

The premorbid personality is an indication of the patient's personality and character before the onset of mental illness. It can be difficult to ascertain retrospectively. Indirect evidence of it can be provided from the personal history (e.g. Have they ever been able to hold down a job or been in a long-term relationship? Have their interests changed?). Patients may be asked directly about their personality before they became ill, or it may be useful to ask a close family member or friend about a patient's premorbid personality.

For example:

*A young man with schizophrenia, with prominent negative symptoms of lack of motivation, lack of interest and poverty of thought, was described by his mother as being outgoing, intelligent and ambitious before becoming ill.*

**COMMUNICATION**

One way to explore premorbid personality in a patient with some insight is to ask questions such as: 'How would people have described you before?' 'How about now?'

# MENTAL STATE EXAMINATION

The MSE describes an interviewer's objective impression of many aspects of a patient's mental functioning at a certain point in time. Whereas the psychiatric history remains relatively constant, the MSE may fluctuate from day to day or hour to hour. It is useful to try and gather as much evidence as possible about the MSE while doing the psychiatric history, instead of viewing this as a separate section. In fact, the MSE begins the moment you meet the patient. In addition to noting their appearance, you should observe how patients first behave on meeting you. This includes their body language and the way that they respond to your attempts to establish rapport.

**COMMON PITFALLS**

The MSE, like a physical examination, is a snapshot of a person's presentation during the interview. Only record what the patient demonstrates or experiences during the interview (e.g. if a patient reports having had a hallucination 5 minutes before you entered the room, that would be described in the history, not the MSE – much as you wouldn't record that someone had had abdominal pain prior to but not during your physical examination). Including history in the MSE is a very common mistake in student case reports.

By the time you have finished the psychiatric history, you should have completed many aspects of the MSE, and you should just need to ask certain key questions to finish this process off. The individual aspects of the MSE, which are summarized in Fig. 1.1, are discussed in more detail below.

There is some variation in the order in which the MSE is reported (e.g. speech is sometimes described before mood, and sometimes before thought form). As long as you include the information, the exact order is not important.

**HINTS AND TIPS**

Don't just ask questions and write down answers! Appearance and behaviour are vital to the mental state examination, especially with less communicative patients. Posture, facial expression, tone of voice, spontaneity of speech, state of relaxation and movements made are all important. You may find it helpful to practise with a colleague – try writing down 10 points that describe their appearance and behaviour.

## Appearance

- *Physical state:* how old does the patient appear? Do they appear physically unwell? Are they sweating? Are they too thin or obese?
- *Clothes and accessories:* are clothes clean? Are accessories appropriate (e.g. wearing sunglasses indoors)?
- *Do clothes match?* Are clothes appropriate to the weather and circumstances, or are they bizarre? Is the patient carrying strange objects?
- *Self-care and hygiene:* does the patient appear to have been neglecting their appearance or hygiene (e.g. unshaven, dirty tangled hair, malodorous, dishevelled)? Is there any evidence of injury or self-harm (e.g. cuts to wrists or forearms)?

## Behaviour and psychomotor function

This section focuses on all motor behaviour, including abnormal movements such as tremors, tics and twitches; displays of suspiciousness, aggression or fear; and catatonic features. Documenting patients' behaviour at the start of, and during, the interview is an integral part of the MSE, and should be done in as much detail as possible. For example:

*Mrs LM introduced herself appropriately, although only made fleeting eye contact. She sat rigidly throughout the first half of the interview, mostly staring at the floor and speaking very softly. She became tearful halfway through the interview*

*when talking about her lack of self-esteem. After this her posture relaxed, her eye contact improved and there were moments when she smiled. There were no abnormal movements.*

The term 'psychomotor' is used to describe a patient's motor activity as a consequence of their concurrent mental processes. Psychomotor abnormalities include *retardation* (slow, monotonous speech; slow or absent body movements) and *agitation* (inability to sit still; fidgeting, pacing or hand-wringing; rubbing or scratching skin or clothes).

Note whether you can establish a good rapport with patients. What is their attitude towards you? Do they make good eye contact, or do they look around the room or at the floor? Patients may be described as cooperative, cordial, uninterested, aggressive, defensive, guarded, suspicious, fearful, perplexed, preoccupied or disinhibited (that is, a lowering of normal social inhibitions; e.g. being overfamiliar or making sexually inappropriate comments), amongst many other adjectives.

**HINTS AND TIPS**

Observations of appearance and behaviour may also reveal other useful information (e.g. extrapyramidal side-effects from antipsychotic medication). It is useful to remember to look for:

- *Parkinsonism:* drug-induced signs are most commonly a reduced arm swing and unusually upright posture while walking. Tremor and rigidity are late signs, in contrast to idiopathic parkinsonism.
- *Acute dystonia:* involuntary sustained muscular contractions or spasms.
- *Akathisia*: subjective feeling of inner restlessness and muscular discomfort, often manifesting with an inability to sit still, 'jiggling' of the legs (irregularly, as opposed to a tremor, which would be regular) or apparent psychomotor agitation.
- *Tardive dyskinesia:* rhythmic, involuntary movements of head, limbs and trunk, especially chewing, grimacing of mouth and making protruding, darting movements with the tongue.

## Speech

Speech should be described in terms of:

- *Rate of production:* pressure of speech in mania; long pauses and poverty of speech in depression
- *Quality and flow of speech:* volume, dysarthria (articulation difficulties), dysprosody (unusual speech rhythm, melody, intonation or pitch), stuttering
- *Word play:* punning, rhyming, alliteration (generally seen in mania)

**COMMON PITFALLS**

Note that disorganized, incoherent or bizarre speech (e.g. flight of ideas) is usually regarded as a thought disorder and is described later in the thought form section.

## Mood and affect

*Mood* refers to a patient's sustained, subjectively experienced emotional state over a period of time. *Affect* refers to the transient ebb and flow of emotion in response to stimuli (e.g. smiling at a joke or crying at a sad memory).

Mood is assessed by asking patients how they are feeling and might be described as depressed, elated, anxious, guilty, frightened, angry, etc. It is described subjectively (what the patient says they are feeling) and objectively (what your impression of their prevailing mood is during the interview) For example, *her mood was subjectively 'rock bottom' and objectively low.* Affect is assessed by observing patients' posture, facial expression, emotional reactivity and speech. There are two components to consider when assessing affect:

1. The appropriateness or congruity of the observed affect to the patient's subjectively reported mood (e.g. a woman with schizophrenia who reports feeling suicidal but has a happy facial expression would be described as having an *incongruous* affect).
2. The range of affect or range of emotional expressivity. In this sense, affect may be:
   - Within the normal range
   - Blunted/flat: a noticeable reduction in the normal intensity of emotional expression, as evidenced by a monotonous voice and minimal facial expression

Note that a *labile* mood refers to a fluctuating mood state that alternates between extremes (e.g. a young man with a mixed affective episode alternates between feeling overjoyed, with pressure of speech, and miserable, with suicidal ideation).

## Thoughts

Problems with thinking are considered under two headings: thought form (abnormal patterns of thinking) and thought content (abnormal beliefs).

### Thought form

Disordered thinking includes circumstantial and tangential thinking, loosening of association (derailment/knight's move thinking), flight of ideas and thought blocking (see Chapter 9 for the definitions of these terms). Whenever possible, record patients' disorganized speech word for

word, as it can be very difficult to label disorganized thinking with a single technical term, and written language may be easier to evaluate than spoken language.

### Thought content: delusions, obsessions and overvalued ideas

It is diagnostically significant to classify delusions as:

- Primary or secondary
- Mood congruent or mood incongruent
- Bizarre or nonbizarre
- According to the content of the delusion (summarized in Table 9.1)

See Chapter 9 for a detailed description of these terms.

An obsession is an involuntary thought, image or impulse that is recurrent, intrusive and unpleasant and enters the mind against conscious resistance. Patients recognize that the thoughts are a product of their own mind. See Chapter 13 for more information.

**COMMUNICATION**

Some psychiatrists include thoughts of self-harm, suicide or harm to others under thought content, while others mention it only under risk assessment. As long as you mention it, it doesn't matter where.

## Perception

Hallucinations are often mentioned during the history. However, this is not always the case, so it is important that you specifically enquire about abnormal perceptual experiences (perceptual abnormalities are defined and classified in Chapter 9). If patients admit to problems with perception, it is important to ascertain:

- Whether the abnormal perceptions are hallucinations, pseudohallucinations, illusions or intrusive thoughts
- From which sensory modality the hallucinations appear to arise (i.e. are they auditory, visual, olfactory, gustatory or somatic hallucinations – see Chapter 9)
- Whether auditory hallucinations are elementary (a very simple abnormal perception; e.g. a flash or a bang) or complex. If complex, are they experienced in the first person (audible thoughts, thought echo), second person (critical, persecutory, complimentary or command hallucinations) or third person (voices arguing or discussing the patient, or giving a running commentary)?

It is also important to note whether patients seem to be responding to hallucinations during the interview, as evidenced by them laughing inappropriately as though they are sharing a private joke, suddenly tilting their head as though listening or quizzically looking at hallucinatory objects around the room.

**RED FLAG**

Elementary hallucinations are more common in delirium, migraine and epilepsy than in primary psychiatric disorders.

## Cognition

The cognition of all patients should be screened by checking orientation to place and time. Depending on the circumstances, a more thorough cognitive assessment may be required. Cognitive tests, including tests of generalized cognitive abilities (e.g. consciousness, attention, orientation) and specific abilities (e.g. memory, language, executive function, praxis, perception), are discussed fully in Chapter 7. Figure 7.1 and Tables 7.1, 7.2 and 7.6 describe methods of testing cognition.

## Insight

Insight is not an 'all or nothing' attribute. It is often described as good, partial or poor, although patients really lie somewhere on a spectrum and vary over time. The key questions to answer are:

- Does the patient believe they are unwell in any way?
- Do they believe they are mentally unwell?
- Do they think they need treatment (pharmacological, psychological or both)?
- Do they think they need to be admitted to hospital (if relevant)?

# RISK ASSESSMENT

Although it is extremely difficult to make an accurate assessment of risk based on a single assessment, clinicians are expected, as far as is possible, to establish some idea of a patient's risk to:

- *Self:* through self-harm, suicide, self-neglect or exploitation by others. Chapter 6 explains the assessment of suicide risk in detail.
- *Others:* includes violent or sexual crime, stalking and harassment. Chapter 32 discusses key principles in assessing dangerousness.
- *Children:* includes physical, sexual or emotional abuse, as well as neglect or deprivation. Child abuse is discussed in more detail in Chapter 30.
- *Property*: includes arson and physical destruction of property.

**RED FLAG**

Risk assessment is a vital part of psychiatric assessment. You should always assess risk to self and others.

## PHYSICAL EXAMINATION

The psychiatric examination includes a general physical examination, with special focus on the neurological and endocrine systems. Always remember to look for signs relevant to the psychiatric history (e.g. signs of liver disease in patients who misuse alcohol, ophthalmoplegia or ataxia in someone withdrawing from alcohol (indicating Wernicke encephalopathy), signs of self-harm in patients with a personality disorder and signs of intravenous drug use (track marks) in patients who use drugs). Also, examine for side-effects of psychiatric medication (e.g. parkinsonism, tardive dyskinesia, dystonia, hypotension, obesity and other cardiometabolic sequelae, signs of lithium toxicity). It may not be possible to complete a detailed physical examination in an exam situation, but you should always recommend that it should be done. Always make a point of mentioning your positive physical findings when summarizing the case.

## THE FORMULATION: PRESENTING THE CASE

'Formulation' is the term psychiatrists use to describe the integrated summary and understanding of a particular patient's problems. The formulation usually includes:

- Description of the patient
- Differential diagnosis
- Aetiology
- Management
- Prognosis

### Description of the patient

The patient may be described: (1) in detail by recounting all the information obtained under the various headings in the psychiatric history and MSE; or (2) in the form of a case summary. The case summary consists of one or two paragraphs and contains only the salient features of a case, specifically:

- Identifying information
- Main features of the presenting complaint
- Relevant background details (e.g. past psychiatric history, positive family history)
- Positive findings in the MSE and physical examination

Table 1.2 shows a case summary as a formulation.

**HINTS AND TIPS**

When presenting your differential diagnosis, remember that two or more psychiatric disorders can coexist (e.g. depression and alcohol abuse). In this event, it is important to ascertain whether the conditions are independent or related (e.g. alcohol abuse that has developed secondary to the depressive symptoms of emptiness and difficulty sleeping).

### Differential diagnosis

The differential diagnosis is mentioned in order of decreasing probability. Only mention conditions that you have obtained evidence about in your assessment, as you should be able to provide reasons for and against all the alternatives on your list. Table 1.2 provides an example of a typical differential diagnosis.

### Aetiology

The exact cause of most psychiatric disorders is often unknown, and most cases seem to involve a complex interplay of biological, social and psychological factors. In clinical practice, psychiatrists are especially concerned with the question: 'What factors led to this patient presenting with this specific problem at this specific point in time?' That is, what factors predisposed to the problem, what factors precipitated the problem, and what factors are perpetuating the problem? Table 1.2 illustrates an aetiology grid that is very helpful in structuring your answers to these questions in terms of biological, social and psychological factors – the emphasis should be on *considering* all the blocks in the grid, not necessarily on filling them.

### Management

#### Investigations

Investigations are considered part of the management plan and are performed based on findings from the psychiatric assessment. Appropriate investigations relevant to specific conditions are given in the relevant chapters. Familiarize yourself with these, as you should be able to give reasons for any investigation you propose.

**Table 1.2** Example of a case formulation (differential diagnosis, aetiology, management)

**Differential diagnosis**

| Diagnosis | Comments |
|---|---|
| 1. Schizophrenia | For: symptoms present for more than 1 month<br>For: ICD-10 and first-rank symptoms of delusions of control or passivity (thought insertion); delusional perception; and third person running commentary hallucinations<br>For: clear and marked deterioration in social and work functioning |
| 2. Schizoaffective disorder | For: typical symptoms of schizophrenia<br>Against: no prominent mood symptoms |
| 3. Mood disorder (either manic or depressive episode) with psychotic features | Against: on mental state examination, mood was mainly suspicious (as opposed to lowered or elevated) and appeared secondary to delusional beliefs<br>Against: no other prominent features of mania or depression<br>Against: mood-incongruent delusions and hallucinations |
| 4. Substance-induced psychotic disorder | Against: long duration of symptoms<br>Against: no evidence of illicit substance or alcohol use |
| 5. Psychotic disorder secondary to a medical condition | Against: no signs of medical illness or abnormalities on physical examination |

**Aetiology**

| | Biological | Psychological | Social |
|---|---|---|---|
| Predisposing<br>(what made the patient prone to this problem?) | Family history of schizophrenia | - | - |
| Precipitating<br>(what made this problem start now?) | The peak of onset for schizophrenia for men is between 18 and 25 years | - | Break-up of relationship Recently started college |
| Perpetuating<br>(what is maintaining this problem?) | Poor concordance with medication due to lack of insight | High expressed emotion family | Lack of social support |

**Management**

1. Investigations
2. Management plan below

| Term | Biological | Psychological | Social |
|---|---|---|---|
| Immediate to short-term | Antipsychotic medication, with benzodiazepines if necessary | Establish therapeutic relationship<br>Support for family (carers) | Admission to hospital<br>Allocation of care coordinator (care programme approach)<br>Help with financial, accommodation and social problems |
| Medium- to long-term | Review progress in out-patient clinic<br>Consider another antipsychotic then clozapine for non-response<br>Consider depot medication for concordance problems | Relapse prevention work<br>Consider cognitive behavioural therapy and family therapy | Regular review under care programme approach<br>Consider day hospital<br>Vocational training |

**Prognosis**

Assuming Mr PP has a diagnosis of schizophrenia, it is likely his illness will run a chronic course, showing a relapsing and remitting pattern. Being a young man with a high level of education, Mr PP is particularly at risk for suicide, especially following discharge from hospital. Good prognostic factors include a high level of premorbid functioning and the absence of negative symptoms.

**CASE SUMMARY**

Mr PP is a 23-year-old, single man in full-time education who recently agreed to informal hospital admission. He presented with a 6-month history of hearing voices and maintaining bizarre beliefs that he was being subjected to government experiments. During this time, his college attendance had been uncharacteristically poor, he had terminated his part-time work, and he had become increasingly socially withdrawn. He has no history of psychiatric illness and denies the use of alcohol or illicit substances; however, he did mention that his maternal uncle suffers from schizophrenia. On mental state examination, he appeared unkempt and behaved suspiciously. He had delusions of persecution, reference and thought control, as well as delusional perception. He also described second person command hallucinations and third person running commentary hallucinations. He appeared to have no insight into his mental illness, as he refused to consider that he might be unwell. There were no abnormalities on physical examination.

### Specific management plan

It may help to structure your management plan by considering the biological, social and psychological aspects of treatment (the *biopsychosocial approach*) in terms of immediate to short-term and medium- to long-term management. See Table 1.2 for an example of this method.

## Prognosis

The prognosis is dependent on two factors:

1. The natural course of the condition, which can be predicted based on studies of patient populations; these are discussed for each disorder in the relevant chapters.
2. Individual patient factors (e.g. social support, concordance with treatment, comorbid substance abuse)

See Table 1.2 for an example.

# CLASSIFICATION IN PSYCHIATRY

There are two main categorical classification systems in psychiatry:

1. ICD-10: the tenth revision of the International Classification of Diseases, Chapter V (F) – Mental and behavioural disorders (published by the World Health Organization). The eleventh revision, ICD-11, is close to completion at the time of writing (https://icd.who.int/browse11/l-m/en).
2. DSM-5: the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (published by the American Psychiatric Association, 2013).

Both the ICD-10 and the DSM-5 make use of a *categorical classification system,* which refers to the process of dividing mental disorders into discrete entities by means of accurate descriptions of specific categories. In contrast, a *dimensional approach* rejects the idea of separate categories, hypothesizing that mental conditions exist on a continuum that merges into normality. This better reflects reality but is harder to put into clinical practice; for example, would someone whose mood is 'one standard deviation lower than normal' be likely to benefit from treatment with an antidepressant?

The ICD-10 categorizes mental disorders according to descriptive statements and diagnostic guidelines. The DSM-5 categorizes mental disorders according to *operational definitions,* which means that mental disorders are defined by a series of precise inclusion and exclusion criteria. Note that the research version of the ICD-10 (Diagnostic Criteria for Research) also makes use of operational definitions.

In general, both the ICD-10 and the DSM-5 propose a *hierarchical* diagnostic system, whereby disorders higher on the hierarchical ladder tend to be given precedence. As a broad rule, symptoms related to another medical condition or substance use take precedence over conditions such as schizophrenia and mood disorders, which take precedence over anxiety disorders. This does not mean that patients may not have more than one diagnosis (which they may); rather, it means that clinicians should:

- Always consider a medical or substance-related cause of mental disorder symptoms before any other cause.
- Remember that certain conditions have symptoms in common. For example, schizophrenia commonly presents with features of depression and anxiety, and depression commonly presents with features of anxiety; in both cases, the treatment of the primary condition results in resolution of the symptoms – a separate diagnosis for every symptom is not needed.

The ICD-10 and the DSM-5 share similar diagnostic categories and are fairly similar for the most part, with further convergence planned between DSM-5 and ICD-11.

The DSM-5 and the current draft of ICD-11 (not yet published) take a lifespan approach to diagnoses. Classification begins with neurodevelopmental disorders (autism, psychotic disorders), followed by disorders that often present in early adulthood (bipolar, depression, anxiety) and ending with neurocognitive disorders (dementia).

These classification systems are evolving over time as new evidence about the aetiology of mental disorders arises. Currently, psychiatric disorders are classified by clustering symptoms, signs and behaviours into syndromes. As yet, they are not based on a clear understanding of pathogenesis. As this develops, classification systems will continue to change and, hopefully, improve.

## Chapter Summary

- A psychiatric history is like any other history, except that more attention is given to personal and social circumstances, and a mental state examination is conducted during it.
- A mental state examination, like a physical examination, is a snapshot of how the person presents at the time you meet them.
- Physical examination is still important, even in patients who don't report physical symptoms.
- Psychiatric diagnostic systems are evolving in light of new understanding of mental disorder aetiology.