Classification and Diagnosis in Psychiatry

Creating groups of diseases - classifications, expresses our knowledge about their relationship. There are two official classifications of psychiatric diagnosis currently used in most of the world. The US and countries that are under strong influence by the US, including most of scientific work done (since the greatest producer of scientific papers in the world is the US, and most renowned scientific journals are located there) use the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM 5). The rest of the world uses the International Statistical Classification of Diseases and Related Health Problems, tenth edition (ICD 10). Since DSM-III there has been a split between those who adhere to DSM because it is a better research classification and those who adhere to ICD because it allows more clinical discretion in making diagnoses. Interestingly, there is still a debate (mainly stimulated by psychologists) whether the same classification should be used everywhere or whether it should exist in parallel with country-specific classification.

Luckily the differences between the two classification systems are small. The main difference is that the ICD still uses a descriptive approach for each disorder, while the DSM since its third edition is formed using lists of diagnostic criteria with a patient needing to have a specific number of the listed symptoms for the diagnoses to be eligible.

Classifications of diseases will have to be regularly revised so we can keep up with the increased knowledge about them and with the improvement of our understanding of their relationships.

Contemporary classifications in psychiatry have their perks and flaws. The main reason for the difference is that still no objective, easily measurable (e.g. blood test), biological cause to any psychiatric diagnosis has been found. Because of this the classifications are based solely on subjective, psychological, psychiatric symptoms whose interpretation can often differ over time, from person to person and from culture to culture.

Medical doctors, and psychiatrists in particular, have to know the language that patients use about their illness and their symptoms. Patients make diagnoses of their condition and place them into some category of their own classification: unless MDes and psychiatrists understand this, they will not be able to raise their patients' self-

esteem, create a therapeutic alliance, jointly decide on the treatment that is best under the circumstances, or do any other therapeutic intervention in a maximum useful way. Beside the diagnosis and disorders used in the classifications, a number of terms are important:

1. Psychotic – Loss of reality testing with delusions and hallucinations.
2. Neurotic – Anxiety caused by intrapsychic conflicts or life events without loss of reality.
3. Functional – No known biological cause.
4. Organic – Caused by objectively measured change in brain (e.g. structural damage after a cerebrovascular insult).
5. Primary/idiopathic – Similar to function, no known cause.
6. Secondary – Similar to organic, symptomatic manifestation of a systemic, medical or cerebral disorder (e.g. delirium resulting from infectious brain disease).

Regarding mental health conditions, DSM and the ICD classifications are divided into 20 and 11 groups of disorders.

The DSM 5 categories:

1. Neurodevelopmental disorders - usually diagnosed in childhood.
2. Schizophrenia Spectrum and Other Psychotic Disorders – (including Catatonia)
3. Bipolar and Related Disorders.
4. Depressive Disorders.
5. Anxiety Disorders.
6. Obsessive-Compulsive and Related Disorders.
7. Trauma- and Stressor-Related Disorders – PTSD among others.
8. Dissociative Disorders – Characterized by detachment from reality which is different than loss of reality. Old word for this, which is not used anymore in psychiatry due to derogatory meaning in modern language, is hysteria.
9. Somatic Symptom Disorders.
10. Feeding and Eating Disorders – Anorexia nervosa among others.
11. Elimination Disorders – Enuresis and encompresis.
12. Sleep-Wake Disorders.
13. Sexual Dysfunctions.
14. Gender Dysphoria.
15. Disruptive, Impulse Control and Conduct Disorders.
16. Substance Use and Addictive Disorders.
17. Neurocognitive Disorders - Dementia, delirium etc.
18. Personality Disorders – Previous DSM was divided into axis I and axis II. Axis II was personality disorders, and axis I were all other disorders. This is changed in DSM 5.

19. Paraphilic Disorders – Paraphilia may also be known among non-psychiatrists as sexual perversion.
20. Other Disorders.
21. Medication-Induced Movement Disorders and Other Adverse Effects of Medication.
22. Other Conditions That May Be a Focus of Clinical Attention - conditions that may interfere with overall functioning but are not severe enough to warrant a psychiatric diagnosis. These conditions are not mental disorders but may aggravate an existing mental disorder.

The ICD 10 categories:

1. Organic, including symptomatic, mental disorders – In here are dementia, delirium, changes due to structural damage etc.
2. Mental and behavioral disorders due to psychoactive substance use.
3. Schizophrenia, schizotypal and delusional disorders – Difference with DSM is that schizotypal is classified as a personality disorder in DSM.
4. Mood (affective) disorders – Both depression and bipolar are under one roof in ICD unlike the DSM. Genetic testing has shown that bipolar is probably more similar to schizophrenia than to depression and therefore the DSM approach here is more science based.
5. Neurotic, stress-related and somatoform disorders – Anxiety, OCD, PTSD, dissociative, somatoform disorders etc.
6. Behavioral syndrome associated with psychological disturbances and physical factors – Eating, sleeping disorders, sexual dysfunctions etc.
7. Disorders of adult personality and behavior – Personality disorders, Impulse disorders and different sexual disorders.
8. *Mental retardation.
9. *Disorders of psychological development – Dyslexia, autism spectrum disorders etc.
10. *Behavioral and emotional disorders with onset usually occurring in childhood and adolescence – Hyperkinetic, conduct, separation anxiety, tic disorders etc.
11. Unspecified mental disorder.

*Diagnosis usually recognized in childhood.

In the year 2022, the eleventh revision of the International Classification of Diseases has been published, with some substantial differences comparing to the previous revision. The chapter 06, *Mental, behavioural or neurodevelopmental disorders*, is comprised of the following:

- Neurodevelopmental disorders
- Schizophrenia or other primary psychotic disorders
- Catatonia
- Mood disorders
- Anxiety or fear-related disorders
- Obsessive-compulsive or related disorders
- Disorders specifically associated with stress
- Dissociative disorders
- Feeding or eating disorders
- Elimination disorders
- Disorders of bodily distress or bodily experience
- Disorders due to substance use or addictive behaviours
- Impulse control disorders
- Disruptive behaviour or dissocial disorders
- Personality disorders and related traits
- Paraphilic disorders
- Factitious disorders
- Neurocognitive disorders
- Mental or behavioural disorders associated with pregnancy, childbirth or the puerperium
- Psychological or behavioural factors affecting disorders or diseases classified elsewhere
- Secondary mental or behavioural syndromes associated with disorders or diseases classified elsewhere
- Other specified mental, behavioural or neurodevelopmental disorders
- Mental, behavioural or neurodevelopmental disorders, unspecified

The conditions that were excluded, comparing to ICD-10 are acute stress reaction and uncomplicated bereavement, while sleep-wake disorders, sexual dysfunctions and gender incongruence were classified elsewhere.

Learning how to communicate should be a lifelong task of all the doctors, from their first contact with people who are asking for medical care, to decision making and follow up of people whom they have treated. The word "doctor" has its origin in "docere", meaning to teach (thus communicate!).

Sartorius&Maric (2017)

Psychiatric History and Mental Status

Psychiatric history – chronologically organized information on recent exacerbations/remissions and current symptoms/syndromes, as well as information about the patient's life, in patient's own words. It should also include the information about the patient from other informants/records. It is essential for diagnosis and treatment formulation.

Identification – name, sex, age, marital status, children, education level, occupation, language, race, nationality, religion; previous hospitalizations (same/different condition); persons living with the patient.

Chief complaints – exact description why patient came to psychiatrist, in patient's own words; note who gave the information, if other than patient.

History of the present illness (chronological background and the development of symptoms) – symptoms: worries, anxiety (free floating/specific), mood changes, preoccupations, suspicions, speech, perceptual experiences, appetite, sleep, libido changes, concentration, memory, behavior (aggressive, impulsive, suicidal), psychophysiological disturbances, pain; illness related changes in personality; onset (sudden/gradual), severity, and duration of symptoms; precipitating factors; previous treatments of this episode (medication parameters, psychotherapy, hospitalizations, treatment outcomes). Personality traits when well.

Past psychiatric and medical history – mental disturbances (chronology of the past episodes, history of suicide attempts/self-harm/aggressive behavior, diagnoses, treatments, hospitals, illness duration, treatment effect; licit/illicit substance use patterns; stressful events); psychosomatic disorders; medical conditions (review of systems, sexually transmitted diseases, infections, risky behaviors, physical injuries); neurological disorders (headache, brain trauma, loss of consciousness, seizures, tumors); medication, hospitalizations, procedures; allergy/adverse reactions; menstrual cycle/menopause; possible secondary gain.

Family history – other people in the home (age, relationship to the patient, occupation, health); family history of psychiatric and somatic illness, psychiatric hospitalizations, involvement with legal system (1st and 2nd degree relatives); living residence, family income, public assistance.

Personal history:

Early childhood (age 0-3): parental age at birth, mother's pregnancy (length, wanted), delivery (spontaneity, normality, birth trauma/defects); feeding (breast/bottle, eating problems); early development (language and motor development, toilet training, sleep, maternal deprivation, unmet needs, object constancy, stranger and separation anxiety); behavioral problems (thumb sucking, nail biting, temper tantrums, tics, auto-aggression, rocking, night terrors, bed-wetting/soiling, masturbation); child temperament (activity, interpersonal patterns); dreams/fantasies.

Middle childhood (age 3-11): feelings about school, achievements; early adjustment, gender identification; conscience, punishment; social functioning (siblings, friends).

Later childhood (prepuberty-adolescence): peer relations (friendships, leader/follower, groups, idols, aggression, antisocial behavior, passivity, anxiety); school history (duration, academic performance, adjustment, relations to teachers, study interests, special abilities and activities); cognitive and motor development (reading, intellectual and motor skills; presence/effects/management of minimal brain dysfunction/learning disabilities); adolescent emotional/physical problems (nightmares, phobias, bed-wetting, running away, delinquency, smoking, alcohol, drug use, weight problems, inferiority); psychosexual history (early curiosity, sexual play, knowledge, parental attitudes, sexual abuse; puberty onset, menarche, secondary sexual characteristics, adolescent sexual attitudes/practices; attitudes to same/opposite sex); religion; stressful events during childhood/adolescence (parental loss, divorce..).

Adulthood: occupational history - occupation choice, training, problems with authority/other peers, sequence and duration of jobs, reasons for change, current job, retirement; social activity - quality of relationships/friendships, with same/opposite sex; adult sexuality - premarital history (age of first coitus, sexual orientation); marital history (age, legal/common-law, partner roles, sexual adjustment, (dis)agreement areas, family planning, children, extramarital affairs, in-laws roles); sexual practices and symptoms (anorgasmia, impotence, premature ejaculation, lack of desire); pregnancy and children related attitudes; military history (adjustment, combat, injuries, psychiatric referral, awards/penalties,

discharge type, veteran); legal history (past or current issues with the legal system); stressful events; value systems.

Approach to the patient

How to start an interview?

Introductory statements and setting the context: 'My name is NN. I have a letter from your MD informing me that you have been feeling low for the past six weeks…'

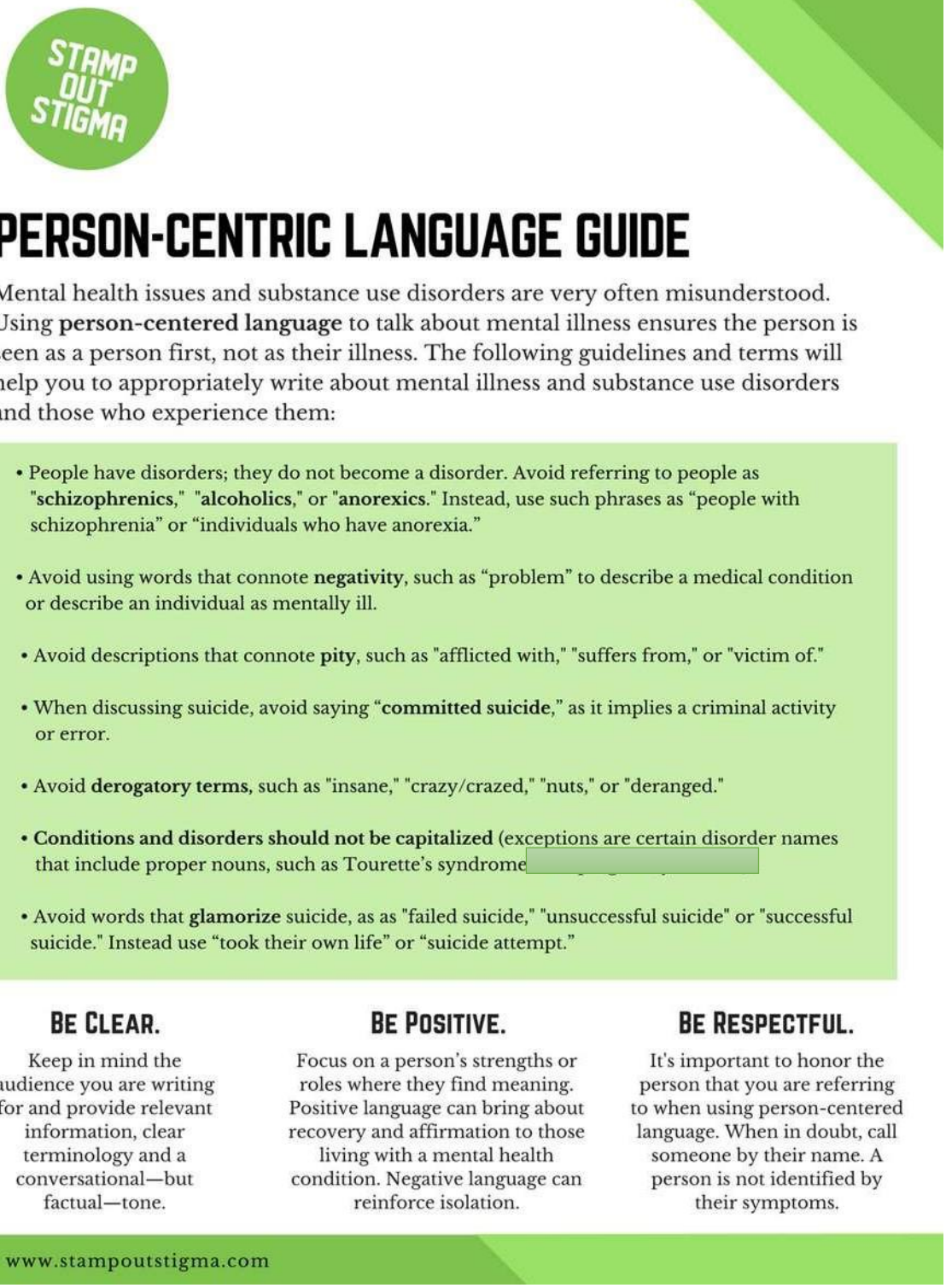
- *"What should I know about your illness?"*
- *"How can I help you?"*
- *"What has worked in the past?"*

  "What have other providers tried that did not work?"

Be specific about identifying data. Note that non-judgmental approach and open-ended questions are preferable with personal history and delicate content.

Which types of questions and of the statements could be used?

- Open questions: "Can I start off by asking how you have been feeling lately?"
- Closed questions: "I understand that you have been hearing voices for several weeks now. Are these voices there all the time?"
- Leading questions: "Your MD has been mentioning sleep difficulties, but you have not mentioned them at all. Let's now focus on your sleep".
- Summary statements: 'From what you have been saying, I understand that you have been feeling low for the past six weeks, and that this has been steadily getting worse to the degree that you are now fearful all the time and for no good reason, and that your sleep has also been badly affected.'
- Normalizing statements: 'It is not uncommon for people in your kind of situation to feel so low that life no longer seems worth living. Have you felt like that?
- Reflective and empathic statements: 'As I understand it, when your husband lost his job you had a lot of money worries. That must have been quite difficult for you, especially in terms of moving to less comfortable apartment and less familiar neighborhood.'
- Concluding statements: 'I now have a good grasp of how things have been for you in the past year. Are there things that you wanted to tell me that you have not yet had the opportunity to bring up?'


STAMP OUT STIGMA
PERSON-CENTRIC LANGUAGE GUIDE
Mental health issues and substance use disorders are very often misunderstood. Using person-centered language to talk about mental illness ensures the person is seen as a person first, not as their illness. The following guidelines and terms will help you to appropriately write about mental illness and substance use disorders and those who experience them:
• People have disorders; they do not become a disorder. Avoid referring to people as "schizophrenics," "alcoholics," or "anorexics." Instead, use such phrases as "people with schizophrenia" or "individuals who have anorexia."
• Avoid using words that connote negativity, such as "problem" to describe a medical condition or describe an individual as mentally ill.
• Avoid descriptions that connote pity, such as "afflicted with," "suffers from," or "victim of."
• When discussing suicide, avoid saying "committed suicide," as it implies a criminal activity or error.
• Avoid derogatory terms, such as "insane," "crazy/crazed," "nuts," or "deranged."
• Conditions and disorders should not be capitalized (exceptions are certain disorder names that include proper nouns, such as Tourette's syndrome
• Avoid words that glamorize suicide, as as "failed suicide," "unsuccessful suicide" or "successful suicide." Instead use "took their own life" or "suicide attempt."
BE CLEAR.
Keep in mind the audience you are writing for and provide relevant information, clear terminology and a conversational—but factual—tone.
BE POSITIVE.
Focus on a person's strengths or roles where they find meaning. Positive language can bring about recovery and affirmation to those living with a mental health condition. Negative language can reinforce isolation.
BE RESPECTFUL.
It's important to honor the person that you are referring to when using person-centered language. When in doubt, call someone by their name. A person is not identified by their symptoms.
www.stampoutstigma.com

Mental status examination – MSE [1]

Mental status – systematic description of the patient's symptoms and signs of mental disorders, present at the time of the interview (data on reported phenomena not present/observable during the interview are recorded in the history).

Appearance and behaviour: general description (posture, clothes, grooming, hair, hygiene, approximate age, masculine/effeminate, having scares, tattoos, signs and shifts of anxiety – moist hands, restlessness…, eye contact (50% is normal)); attitude toward examiner (cooperative, frank, hostile, guarded..); behavior and psychomotor activity (gait, involuntary movement, akathisia, mannerisms, stereotypes, echopraxia, hyperactive, agitated, waxy, catatonic posturing…);

Speech: rhythm, accent & intonation (prosody), rate, reaction time, volume, amount, fluency, articulation, spontaneity, vocabulary (rapid/slow, pressured, hesitant, emotional, monotonous, loud/whispered, slurred, stuttering, echolalia…).

Mood and affect:

Mood (internal, subjective, sustained emotional state; reported by patient): depth, intensity, duration, fluctuations (e.g. depressed, anhedonic / expansive, euphoric / anxious / irritable / alexithymic…); does the patient have thoughts that life is not worth living, that he/she wants to die, or has thoughts/plans of self-harm / taking his/her own life?

Affect (externally observable and more changeable emotional state; evaluated by examiner): range, intensity, stability, appropriateness, congruence, problems with initiating, sustaining, terminating an emotional response (e.g. broad, restricted, blunted, flat, shallow …); nonverbal signs - facial and body expressions, voice prosody.

Thinking and perception:

[1] *Modified from Kaplan-Sadock – Pocket Handbook of Clinical Psychiatry - 6th edition (2019), Wolters Kluwer*

Form of thinking: productivity – tempo, quantity (rapid/slow, hesitant thinking, overabundance, paucity, flight of ideas, speaks spontaneously/only when asked..); continuity of thought (are replies really answering the questions, goal directed, relevant/irrelevant; loose associations; lack of cause-and-effect; illogical, tangential, circumstantial, rambling, persevering statements; blocking, distractibility); language impairments (incoherent/incomprehensible speech (word salad), clang associations, neologisms).

Content of thinking: ruminations/preoccupations (illness, environmental problems); obsessions, compulsions, phobias; obsessions or plans about suicide, homicide; hypochondriacal symptoms, specific antisocial urges or impulses.

Thought disturbances: delusions; ideas of reference/influence; thought broadcasting; thought insertion / withdrawal.

Perception disturbances: hallucinations (a perception in the absence of a stimulus) and illusions (an incorrect perception in the presence of a stimulus); depersonalization, derealization (extreme experience of detachment from self/environment).

Dreams and fantasies: dreams (prominent ones, recalling, nightmares), fantasies (recurrent, favorite, daydreams).

Sensorium:

Describes the overall intactness of the central nervous system, abnormalities (in delirium, dementia) speak in favor of the possible underlying medical/drug-related cause:

Alertness (awareness of environment, attention span): fluctuations in levels of awareness, somnolence, lethargy, stupor, sopor, coma, clouding of consciousness, fugue state.

Orientation – time (identifying the day, date, time of the day, does he/she behaves as oriented); place (knowing where he/she is); person (knowing who the examiner is, the roles and names of persons in contact); self (patient knowing who he/she is).

Concentration and calculation – tasks: subtract 7 from 100 and keep on subtracting 7s; simple calculations (4x9 and 2x3); calculating how many fifty-cent-euro coins are in 13.5 euros. Are difficulties caused by anxiety/mood disturbances? Tasks should be congruent with patient's educational level.

Memory (registration, retention, recollection) **-** remote memory (childhood data, important events from the patient's youth or before the illness, neutral data); recent past memory (past few months); recent memory (what did the patient do, eat, yesterday, the day before); immediate retention and recall (repeating 6 figures after examiner dictates them – forward, backward, and after interruption of few minutes; asking patient to remember 3 nonrelated items, and repeating them after 5 minutes; repeat same questions after a while); *effect of defect on patient* (coping - denial, confabulation, catastrophic reaction, concealing).

Fund of knowledge - intellectual capability of functioning at the level of his/her basic endowment (brief structured tests – e.g. Scored General Intelligence Test); general knowledge (questions with relevance to his/her educational and cultural milieu: distance between cities, naming some vegetables, largest river in the country).

Abstract thinking – concept formation problems, conceptualization and handling ideas, similarities (apples vs. pears, bird vs. butterfly; bread vs. cake), differences, absurdities, simple proverbs meanings (concrete/overly abstract answers), answer appropriateness.

Insight *(severely impaired in psychosis, cognitive disorders, borderline IQ)* – does the patient recognize he/she has a mental disorder, understanding of illness and treatment benefits (do you think you have a problem, do you need treatment, what are your plans for the future?); *Levels of insight*: 1) complete denial of illness; 2) slight awareness of not being well and needing help, with denial at the same time; 3) awareness of being sick but blaming it on others, external, medical or unknown organic factors; 4) intellectual insight – accepting illness, recognizing that symptoms result from disturbances, without applying to future experiences; 5) true emotional insight – emotional awareness of the motives, feelings, meaning of symptoms, awareness leading to future behavior changes, openness to new ideas about self and significant others. *Stages of change:* 1) precontemplation (denial, minimization), 2) contemplation (thinking about doing something), 3) preparation (getting ready to do something), 4) action (implementing concrete actions), 5) maintenance (ensuring the maintenance of change).

Judgement (*severely impaired in cognitive disorders, and manic episodes of bipolar disorders*) – social judgement (subtle signs of auto-harmful and socially unacceptable behavior, understanding the likely outcome of own behavior, does this understanding influence him/her; give examples), test judgement (what he/she would do in imaginary situations – e.g. if he/she found a stamped addressed letter in the street, or felt smoke in the theatre).

Psychiatric report and medical record

The psychiatric report consists of:

1. Psychiatric history
2. Mental status
3. Diagnosis
4. Comprehensive treatment plan

When writing a psychiatric report use specific examples of what questions are asked and how they are answered. Try to summarize the case not only from a descriptive approach, but also from an interpretative standpoint.

1. Psychiatric history consists of:

a) Identification of patient (name, age, working, living and family status);
b) Chief complaint;
c) History of present illness;
d) Past psychiatric history;
e) Medical history (allergies, surgeries, acute or chronic somatic illnesses, treatment other than psychiatric, history of use or abuse of psychoactive substances including alcohol, for women menstrual status /mainly is the person in menopause/);
f) Family history (here describe both family history of psychiatric disorders and the relationship the patients have with closest family members; also when asking about family history of psychiatric disorders, ask separately about alcohol abuse and suicide since these two often happen in untreated individuals so patients don't consider them as psychiatric problems /since they weren't treated or because they think that drinking or suicide was done due to weak will power, and not mental disorders/);
g) Premorbid functioning.

2. Mental status.

Objective assessment of the patient's mental status at the interview consists of:

a) Appearance and behavior;

b) Motor activity;

c) Speech;

d) Mood and affect;

e) Thinking and perception;

f) Sensorium;

g) Insight and judgement.

3. Diagnosis.

Three main things to find out at the end of examination: (1) presence or absence of psychosis, (2) cognitive defect, (3) if patient is suicidal or homicidal.

More than one diagnosis can be diagnosed. The **principal diagnosis** is the one that is responsible for the admission or the visit at the moment of the interview: e.g. patient has anorexia nervosa and borderline personality disorder, but has come to the psychiatrist because of feelings of sadness and suicidal ideations due to breakup with boyfriend. So principal diagnosis would be major depressive episode, and secondary anorexia nervosa and borderline personality disorder.

When two diagnoses are equally important, we use **dual diagnosis**: e.g. patient with anorexia nervosa comes to psychiatrist because she recognizes that her eating disorder has become an issue and she has become depressed because of it. When we are not sure, or do not have enough info to make a definitive judgement about a diagnosis, we use a **provisional diagnosis**.

Severity of diagnosis is classified as:

a) Mild;
b) Moderate;
c) Severe;
d) In partial remission;
e) In full remission.

Optional - Psychodynamic formulation. It defines the underlying mechanisms that contribute to the psychiatric disorder in the patient. Here the therapist should recognize **(these are usually not known and verbalized directly by the patient)** primary or secondary gain, personality factors, defense mechanisms that are present and the way they influence the current state of the patient. The main question is in which way do these factors help or exacerbate psychiatric symptoms and how do they influence the treatment plan and prognosis for this particular patient.

4. Treatment plan.

The most important thing to assess is suicidal risk or danger to others. If the danger to self or others is recognized, hospitalization is the preferred mode of treatment. If the hospitalization should or could be involuntary depends on legal restrictions. How strict are restrictions for involuntary hospitalization depends on the laws of the country where the patient is at the moment and differs very much from country to country. When starting your medical practice make sure to learn the legal obligations and restrictions for involuntary hospitalization in your country of work.

Even though these two are the most important questions, they should not be asked at the start of the interview but rather later on when the patient and therapist have made some basic form of trust and the patient is a little bit more relaxed. Non the less the questions should not be avoided at any cost and should be asked directly and clearly: e.g. „Have you had thoughts about taking your own life?“

When the psychiatrist finishes the interview, he should also formulate a comprehensive treatment plan. This consists of the assessment on the need for:

a) medication;
b) individual, group, or family psychotherapy;
c) inpatient or outpatient treatment:
    i) if inpatient treatment is needed, is it on a ward or day hospital;
    ii) if outpatient treatment is needed how frequent should controls be;
d) referral to a psychologist, social worker, occupational therapist, or other medical professional (e.g., neurologist);
e) other testing (e.g., EEG, CT, thyroid hormone tests, etc.).

At the end of a hospitalization a **discharge summary** is written with a concise overview of the patient's course and recommendations for future treatment.

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MENTAL STATE EXAM FORM

Name of the patient:	
1. Appearance and behavior *(observed)*	**General description:** Approximate age: Clothes, grooming, hygiene, marks and signs of anxiety *(tick)*: □ Casual dress, normal grooming and hygiene □ Other *(describe)*: Posture *(describe)*: Eye contact *(tick)*: □ Normal □ Other *(describe)*: **Attitude towards examiner** *(tick)***:** □ Cooperative, frank, hostile, guarded, suspicious, apathetic, easily distracted, defensive (*circle*); □ Other *(describe)*: **Behavior & psychomotor activity:** Gait *(tick)*: □ Normal □ Other *(describe)*: Facial expression (*describe*): Unusual movements and psychomotor changes *(tick)*: □ No unusual movements or psychomotor changes □ Other *(describe)*:
2. Speech *(observed)*	Rhythm, accent, intonation (prosody), rate, reaction time, volume, amount, fluency, articulation, spontaneity, vocabulary, with/without pressure *(tick)*: □ Normal □ Other *(describe)*:
3. Mood *(inquired)* & affect *(observed)*	Mood (tick): □ Euthymic (normal) □ Depressed □ Elevated (euphoric, expansive) □ Irritable □ Anxious □ Alexithymic □ Other (describe): Affect (circle within each bullet): • Normal range / Other (describe): • Normal intensity / Other (describe): • Stable / Other (describe): • Appropriate / Other (describe): • Congruent / Other (describe): • No problems initiating, sustaining or terminating emotional response / Other (describe):
4. Thinking and perception *(inquired/observed)*	**Form of thinking:** Productivity – tempo, quantity *(circle within each bullet)*: • Normal / Other *(describe)*: Continuity of thought *(circle within each bullet)*: • Goal-directed and logical / Other *(describe)*: Language impairments *(circle within each bullet)*: • No impairments / Other *(describe)*: **Content of thinking and thought disturbances** *(tick)***:** □ no disturbances □ ruminations /preoccupations *(describe)*: □ obsessions/compulsions *(describe)*: □ phobias *(describe)*: □ hypochondriac preoccupations *(describe)*: □ delusions *(describe)*: □ ideas of reference/influence □ thought broadcasting □ thought insertion / withdrawal

	☐ other *(describe)*: ☐ suicidal preoccupations (thought, intent, plan, means - *describe)*: ☐ antisocial urges/impulses; homicidal preoccupations (thought, intent, plan, means - *describe)*: **Perception disturbances** *(tick)***:** ☐ No disturbances ☐ Hallucinations *(describe):* ☐ Illusions *(describe):* ☐ Depersonalization / derealization ☐ Other (*describe*):
5. Sensorium ***(inquired/observed)***	**Alertness** *(tick)***:** ☐ Intact ☐ Fluctuations in awareness levels ☐ Somnolence ☐ Sopor ☐ Stupor ☐ Coma ☐ Clouding of consciousness ☐ Fugue state ☐ Other *(describe)*: **Orientation** *(tick)***:** ☐ Intact ☐ Disoriented in time ☐ Disoriented in place ☐ Disoriented towards person ☐ Disoriented towards self **Concentration and calculation** *(tick)***:** ☐ Intact ☐ Problems in tasks of subtracting and other calculation *(describe)*: ☐ Other *(describe – e.g. difficulties caused by anxiety/mood disturbances)*: **Memory** *(circle within each bullet)***:** • Remote memory: intact / disturbed (*describe*): • Recent past memory: intact / disturbed (*describe*): • Recent memory: intact / disturbed (*describe*): • Immediate retention and recall: intact / disturbed (*describe*): • Other *(describe – e.g. difficulties caused by anxiety/mood disturbances)*: • Effect of defect on patient (coping): denial / confabulation / catastrophic reaction / concealing / other (*describe*): **Fund of knowledge** *(tick)***:** ☐ Intellectual capability *(circle)*: average / above average / below average ☐ General knowledge (*circle*): congruent with the patient's educational and cultural milieu / other (*describe*): **Abstract thinking** *(tick)***:** ☐ Intact ☐ Other *(describe)*:
6. Insight and judgement	**Overall** (*tick)***:** ☐ Good ☐ Fair ☐ Poor (impaired)

Miscellaneous

Mental status examination – narrative report examples

Patient with Major Depressive Disorder

(Appearance and behaviour): Ms SJ is a 52-year-old female of average weight, who appears to be slightly older than her stated age. She is appropriately dressed for the season, but not well-groomed. She has a hunched posture during the interview. Her eye contact is reduced, but she presents a cooperative attitude towards examiner. She has a worried face expression, with the sign of "omega" on her forehead, and her overall psychomotor activity is slow, with no observable involuntary movement. ***(Speech):*** She answers questions in a direct and logical fashion, with prolonged reaction time. Her speech is slow, her tone of voice has monotonous quality, with reduced spontaneous production. ***(Mood and affect):*** Her mood is moderately to severely depressed. During the interview, her affect is congruent with thought content, with no visible intensive fluctuations. ***(Thinking and perception):*** She displays a slow, but logical, coherent, sequential flow of thought, with reduced spontaneous production. Content of thinking is dominated by ruminations about her low self-worth, low support from others and negative view of future (Beck's cognitive triad). She has thoughts that life is not worth living, thought she denies any suicidal or self-harm tendencies (plans). She denies homicidal thoughts and tendencies. There are no signs of delusional or obsessive thinking. No evidence of perception disturbances is reported by the patient, or displayed during the interview. ***(Sensorium):*** She appears alert and well oriented in time, place, towards person and self. She has difficulties concentrating on the tasks of calculation, which seems to be influenced by the mood. She has slight difficulties in immediate retention and recall, with no other memory disturbances observed. Her intellectual capability and general knowledge correspond to the average level, with no difficulties in abstract thinking. ***(Insight and judgement):*** The patient recognizes that she has a mental health problem at the level of intellectual insight, and she was in a contemplation phase of change. No evidence of social and test judgement impairment is displayed by her during the interview (no evidence of a risk for violence or inadequate impulse control).

Patient with Generalized Anxiety Disorder (GAD)

(Appearance and behaviour): Ms JV is a 24 year old female of thin build who appears to be her stated age. She is neatly dressed in jeans and a sweater and her general hygiene is impeccable. She is mostly pleasant and cooperative but avoided eye contact occasionally while talking about her worries. Anxiety has been noticed. Ms J exhibits restlessness at moments while sitting in her chair, with observed fine tremor of her hands and cracking fingers. However, she had no noticeable gait disturbance upon entry and she had no evidence of tics, gestures, dyskinetic movements or akathisia. ***(Speech):*** Her speech is fluent and with appropriate rate and rhythm. ***(Mood and affect):*** Her mood is mildly depressed. Her affect is labile and congruent with thought content. ***(Thinking and perception):*** Thought process is coherent, goal-directed and appropriate. Her thought content was notable for excessive worries about everyday life circumstances and events. She denies any preoccupations, obsessions and delusions. She denies any current suicidal or homicidal ideations, intent or plan. Ms J denied auditory, visual, olfactory, tactile and gustatory hallucinations. ***(Sensorium):*** Ms J is alert, oriented to time, place, person and self. Her memory is intact, including remote, recent, and immediate memory. Concentration and calculation are intact. The patient is able to perform simple arithmetic calculations and serial subtraction by 7s. Her intelligence was estimated to be an average. Fund of general knowledge appears to be adequate. Her abstraction of proverbs and symbolization were good. ***(Insight and judgement):*** Ms J's insight and judgment are fair.

Patient with alcohol intoxication

(Appearance and behaviour): Mr MG is a 42-year-old male of average weight, who appears to be of his stated age. He wears a sleeveless shirt in spite of the cold weather, and his clothes give untidy impression. At the entrance, he has ataxic gait and posture, and was assisted by a family member. His movements are discoordinated. His eye contact cannot be maintained, and he has a defensive, at times hostile attitude towards the examiner. His face expression changes from sleepy to upset, and his overall psychomotor activity is fluctuating from slow to agitation. ***(Speech):*** He has a slow and slurred, at times completely incomprehensible speech, with reduced production, and he does not answer the questions directly. ***(Mood and affect):*** His mood is irritable. His affect is labile. ***(Thinking and perception):*** His flow of thought is incoherent. Content of thinking cannot be assessed, suicidal and homicidal potential cannot be examined due to the impairment of communication. The patient's verbalization and behavior point out to visual illusions (he perceives hanged coats as people). ***(Sensorium):*** Mr M's alertness is impaired in the form of fluctuating awareness/confusion. He is disoriented in time and place, with preserved orientation to person and self. He is not able to concentrate on any given cognitive tasks. His memory is damaged in the form of confabulations. His basic intellectual capability and general knowledge could not be assessed. ***(Insight and judgement):*** The insight and the judgement of the patient are impaired, with a risk of aggressive behavior.

Patient with dementia

(Appearance and behaviour): Ms RD is a 70-year-old female of average weight, who appears to be of her stated age. She is appropriately dressed for the season, but her clothes look somewhat untidy. She has a hunched posture during the interview. Her eye contact is mostly normal, with a several episodes of „absent“ gazing into a different direction. At the first glance, she presents a cooperative attitude towards examiner, but further on during the conversation she becomes defensive at moments. Her motor activity shows signs of restlessness, without any noticeable gait disturbance or tics, gestures, dyskinesia or akathisia. Elements of dyspraxia are observable. ***(Speech):*** She spoke in a mildly slower than average manner, with reduced spontaneous production, at times giving „near-to-miss“ answers to questions. ***(Mood and affect):*** Her mood is moderately anxious, irritable at times. Her affect is labile and shallow. ***(Thinking and perception):*** Flow of thoughts is easily distracted and fragmented by longer empty pauses. Thought content is dominated by ruminations, with no clear signs of delusional thinking. She denies any suicidal or homicidal ideas or tendencies. Perception is disturbed in the form of visual agnosia. ***(Sensorium):*** Mr R's has a clouded sensorium, with clear disorientation in time and space, and some disorientation towards person. Her remote memory is dominantly preserved, with amnesia for recent memory, and disturbances in immediate memory. The gaps in memory are filled in with confabulations. She has difficulty concentrating, and fails to perform simple arithmetic calculations and serial subtraction by 7s. Her intellectual capability and general knowledge are declined, with failure in abstract thinking. ***(Insight):*** She has slight awareness of not being well and needing help, with denial at the same time. Her social and test judgement are impaired.

Peek into the Psychiatric Day Hospital

Day Hospital for Adults

Treatment plan for patient with mixed anxiety–depressive condition in the local Day Hospital

Things to consider

Psychiatric diagnosis are constructs. This means that the diagnosis is not based on the cause of the disorder, since these are unknown for the vast majority of psychiatric disorders, but on descriptions of symptoms. This isn't good or bad in itself, it is just the *zeitgeist* [2]we are in. Since we do not have knowledge for causal diagnosis, we need to make compromise, the best way we know, and that is based on constructs formed around observed symptoms. Sometimes this is sufficient and unproblematic, but sometimes it leads to controversy. Two problems are the cause for this controversy.
First one is false positive and false negative cases. Since many experiences a person can have in the psychological sphere may be normal (fear, sadness, guilt, etc) they are defined as abnormal when they pass a threshold (when their intensity is high and lasts long). What is high and what is long is a subjective notion, and therefore some people who may need professional help may not fullfill criteria for the diagnosis, while others who are having a normal reaction to social stressors may be diagnosed with a disorder. In professional circles there are two prevailing, opposing naratives. One is that not enough people are seeking and getting help because of stigma, while the other is that too many people are being diagnosed and treated for normal human emotions and their manifestations (overdiagnosis and overtreatment). Both of these groups lean into the basic problem of the diagnosis itself, the lack of causality and diagnosis as a construct which is man made, and therefore imperfect. In some diagnosis this is much less of a problem (anorexia nervosa, schizophrenia) then in others (ADHD, depression).
Second problem is that as such there is often overlap between diagnosis, called comorbidity, which again is <u>often</u> not true comorbidity (meaning existance of two or more disorders simultaneously) but an artifact of the imperfect diagnosis as a construct. The most obvious example of this is the comorbidity between anxiety and depression, since some studies find that as much as 95% of patients with generalized anxiety disorder have comorbidity with depressive disorder. In fact „sadness" and „fear" more often than not in life go hand in hand, and therefore in diagnostic criteria the line is not clear either. It should be stated that comorbidity can be very beneficial for the psychiatrist because even if sometimes it is not true comorbidity it tells the physician that a condition is much more complicated because of the various symptoms or factors that influnece the relation.
Because of this when we discuss the treatment plan for depression or anxiety (again, we are talking specifically for anxiety and depression since other diagnoses carry different rules, benefits and problems, and therefore this paragraph is not necessarily applicable to all diagnoses the same way) we can talk about the same treatment plan, which is not the same for every individual patient. The treatment plans regarding depression and anxiety as similar entities are not made based solely on the sypptoms, but also on the social circumstances.

The treatment components in the Day Hospital[3]

The main activity and possibly the main way of help for most patients is the inclusion of the patient within a group of people, with same or similar problems. The very nature of this group leads to support, from each member, being a part of a group, which is in today's *zeitgeist* where loneliness is on the rise, and social support dropping, of immeasurable importance. Among activities some might even seem simple, such as quizzes or some games, but in adition to the effect of relaxation, they help streangthening the overall bond of the group. Through this the bonds sometimes become so strong that they turn into friendships, which helps in maintaining the improvement achieved within the Day Hospital, even after discharge.

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[2] *Spirit or mood of a particular period of history; the general intellectual, moral, and cultural climate of an era.*
[3] *The description shows an example of the Day Hospital for Adults at the Institute of Mental Health, Belgrade*

Studies have shown time and again that a daily routine is extremely important for a person. Day hospital introduces this to people who don't have it, such as unemployed, students etc, with the need to come at 9h each workday, and leave by 13:30h. It also helps people who have extremely stressful work, that might excacerbate their anxiety or depression, or if they are not able to work due to drop in focus. This way they keep the daily routine, but without the stress and work expectations.

1. Daily workout sessions. Even though they are light in intensity, for some who have sometimes neglected this part of their health for years even, they are worthwhile. And besides the physical benefits of this activity, the link between physical activity and wellbeing is proven in studies, and in the latest meta analysis it was shown that physical activity is as effective for mild depression as antidepressants.

2. Group therapy is performed also daily. It brings relief to patients to „get things off the chest", get advice and support from the group, and the psychological change is facilitated by the group psychotherapeutic factors.

3. Psychiatrists and psychologists talk to patients. The treatment plan is individualy tailored.

4. Some patients have specific, problematic family situations, or the family simply needs to be educated to better help the patient. In these cases family members of interest are called for talks, usually with the patient present, but if need be alone as well, but only with the approval of the patient.

5. A social worker also advises patients on matters regarding social welfare and legal matters. If needed social workers sometimes visit the place of work to better understand the conditions and if possible help in better job accomodation for the patient if possible. All of this is again done only with explicit approval from the patient.

6. Lastly, pharmacotherapy is adjusted to the condition of the patient, but the focus is on prescribing the minimum effective dose and the minimal number of medications possible. Polipharmacy is prevalent in psychiatry, often due to the insufficient improvement of the condition which could be influenced by negative social circumstances. In the day hospital, with the comprehensive approach and focus on social aspects, there is often improvement through those means, which offers a chance to lower drug doses and even exclude drugs where possible.

All in all, the Day Hospital offers a wide range of social, psychological and pharmacological treatment options suited for every depressed or anxious (or usually both) patient. It also potentiates healthy aspects of a person, with the aim of lowering pharmacological overtreatment.

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What if the patient with mixed anxiety-depressive condition is not able to access a Day Hospital?

Unfortunately, sometimes patients cannot afford the "luxury" of day hospital treatment. It could be due to the need to care for a sick loved one, or they simply aren't in position to take on longer sick leave, or are living too far for it to be feasible. In these cases, the outpatient physician can still implement some of the aspects that are used in the Day hospital. It is important that the physician tries to pay careful attention and understand the social context of the patient. Sometimes the patient just needs empathy, support and advice. Changes in the daily routine and physical activity are a possibility for almost everyone, and even though many are aware of this they avoid it. Here the professional authority of the physician and the therapeutic alliance is often enough to motivate a person (patient) to do it. Poverty is one of the main risk factors for depression. Motivate the patient

to seek help from social services, or even brainstorm with them on the possibilities for a job. Patients who have financial security may be motivated to start psychotherapy.

Pharmacotherapy has an important place in psychiatric treatment of this group of patients. However, it is important to try to avoid polypharmacy (when possible), and in case a medication shows no intended effect, it should be excluded from the prescription. As Prof. Michael Steinman puts it (not just for psychiatric drugs) "medications are sticky and deprescribing is a behavior that requires motivation on both the physician's and patient's side". It is important to avoid the trap that sometimes happens, where physicians out of inability to influence social circumstances and the desire to help the patient in some way, starts prescribing more and more drugs, harming the patient in the long run. The creeds *primum non nocere*, and *the road to hell is paved with good intentions*, should always be kept in mind of a physician.

Day Hospital for Adolescents

Treatment plan for adolescent and emering adult (15-24 y.o.) patients in the local Day Hospital for Adolescents

Things to consider

Adolescence and emerging adulthood are periods of complex developmental changes, associated with both opportunity and vulnerability when it comes to mental health. **Half of all mental health problems appear by the age of 14, potentially leaving mental health "scars" throughout the life span**. The most common mental health problems in this age are associated with symptoms of depression and anxiety. Specific psychopathology begins to develop at this stage of life and is partly influenced by the psychodynamics of the process of adolescence itself. Therefore, when psychiatric treatment is required, the fragile self-image of adolescents and their generally unstable self-esteem become even more relevant, especially if intensive treatment in a hospital setting is required. Consequently, intensive treatment should be adjusted to the needs of adolescents' emotional development. In emotional disorders of youth, the central element of the treatment are psychosocial interventions, with the "adjuvant" prescription of the psychopharmacotherapy where needed, following **the principle of the minimum effective dose** and paying special attention to the patients' perception of medication and possible side-effects that may be particularly problematic in this developmental period.

The treatment in day hospital offers young people the intensive milieu of key psychosocial interventions, relying on the "group factor" that is especially important in this age, without significant stigma and major disruptions of the lifestyle continuity as seen in inpatient settings. Day Hospital for Adolescents -DHA should enable such a treatment to groups of adolescents and emerging adults with the most common emotional disorders - depressive disorders, anxiety disorders, adjustment disorders, mixed disorders of conduct and emotion.

The treatment components[4]

At admission, the young patient is clinically assessed by a psychiatrist. Throughout the hospitalization that approximately lasts for two months, psychological testing, neurological and EEG examination, and laboratory testing are indicated.

Upon admission, and throughout the entire hospitalization, each patient is thoroughly followed by the case-management team (CM team), the core of the DHA concept. The CM team includes a psychiatrist, a psychologist/social worker/psychiatric trainee, and nurses, who gather once a week. The objective of the team is to observe the patient from different professional perspectives and to

[4] *The example is showing Day Hospital for Adolescents at the Institute of Mental Health, Belgrade; Modified from: Bradic Z, Kosutic Z, Mitkovic Voncina M, et al. Psychiatr Serv. 2016 Sep 1;67(9):943-5.*

exchange thoughts and experiences at general team sessions (the synthesis team), which are held four days each week. This kind of approach takes into account the daily contacts and interactions that take place at DHA between the adolescents and mental health care providers, among the adolescents themselves, and among the team members.

The treatment program includes individual psychosocial treatment (psychotherapy), pharmacotherapy (if needed), and daily structured milieu therapy. The central component of the milieu therapy is psychodynamic group therapy adapted from Yalom and Leszcz's acute-phase inpatient group therapy. Other components of milieu therapy are psychodrama workshops, cognitive-behavioral therapy groups (life skills learning and assertiveness training), psychoeducational groups, art and occupational therapy, bibliotherapy, music and film therapy, adolescent assembly (patient-led meetings during which current issues are discussed), and therapeutic community (staff-led meetings during which adolescents are given their weekly responsibilities in the DHA group setting and group issues are discussed with the staff). Special attention in the therapeutic process is given to working with parents through the Parents Counseling Service, which offers psychoeducation groups, individual counseling, and family therapy. Also, the DHA collaborates with schools, social welfare, and legislative institutions.

After the discharge from hospitalization, the young patients in post-recovery period are followed through outpatient service for adolescents by the same psychiatrist, as they get back to their everyday functioning. Group continuity after hospitalization in the DHA is maintained through a staff-led Club for Adolescents, with one session per month, involving artistic activities and peer self-help groups, as well as in so-called "prolonged" group sessions once per week, for more fragile patients.

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Vignettes and MCQ – The Practical Exam

Example 1

S is a 30-year-old male with paranoid schizophrenia. He stopped his medications 3 weeks ago. In response to the voices that followed, he then stopped eating and drinking. The voices have been telling him that his food is poisoned. “They put rat poison in your food” the voices told him. His mother became concerned when he wouldn’t eat for two days. She made him several of his favorite foods and tried to convince him to eat but he barricaded himself in his room and would not come out for 24 hours. His mother then called emergency service. You interview him in the emergency room after he is brought into the hospital.

1. Which of the following statements would you include in his mental status exam given what you know at this point?

A Thought content includes paranoid delusions
B Thought content includes auditory hallucinations
C Thought process includes flight of ideas
D Perceptions include auditory hallucinations

2. You begin to perform a mini-mental status exam on S. You ask him to count backwards from 100 by 7s. He replies “93, 89, 81, 74.” You ask him if he can go further and he replies “Go to hell. I am the chosen one. I won’t do anything I don’t want to.” How would you document this exchange? (choose 2 of 4)

A Memory is intact
B Concentration is impaired
C Abstract thinking is intact
D Attitude is hostile

3. The mesocortical pathway which is responsible for the _____ symptoms of schizophrenia begin at the _____.
A Positive; ventral tegmental area
B Negative; nucleus accumbens
C Positive; nucleus accumbens
D Negative; ventral tegmental area

Example 2

A23-year-old woman presents to clinic with a chief complaint of “difficulty concentrating because I worry about my child.” She had recently gone back to teaching after having her third child. The patient states she is constantly wondering about other things as well. For example, she is going to help her sister-in-law throw a goodbye party and finds herself constantly going over what she needs to do to prepare for the party. At the end of the day, her husband claims she is irritable and tired. At night, she is unable to sleep and keeps thinking about her tasks for the next day.

1.What is the most likely diagnosis?

A. Avoidant personality disorder
B. Obsessive-compulsive disorder
C. Obsessive-compulsive personality disorder
D. Generalized anxiety disorder
E. None of the above

2. For this patient, you will prescribe benzodiazepines (two correct answers):

A. As a monotherapy for a few months
B. As adjuvant therapy to SSRI for a few weeks
C. As adjuvant therapy to antipsychotics as needed
D. As adjuvant therapy to mood stabilizers as needed
E. The first choose could be non-pharmacological intervention (psychotherapy)