Practical Psychiatry in Medicine
Part 16. Psychiatric Evaluation of the Medical Patient

Psychiatric evaluation closely resembles the rest of medical evaluation in its goals and methods.

The ultimate goal of the psychiatric evaluation is to establish a comprehensive diagnosis which can lead to an effective plan of management.[2] Comprehensive psychiatric diagnosis includes several components, which will be described below.

Methods of psychiatric evaluation consist of history taking, examination of the patient's mental functioning, and the interpretation of appropriate special tests or procedures. Most information comes through the interview with the patient, and the principles and techniques of this essential procedure will be discussed in detail.

One must decide how extensive the psychiatric evaluation should be for a particular patient. Several factors enter into this including presentation of evidence suggesting psychiatric conditions, the probable diagnosis, and the severity and urgency of the patient's problems. In addition, the primary physician will generally conduct a more extensive psychiatric evaluation when he plans to assume continuing responsibility for clinical management, with or without psychiatric consultation; if he plans to refer the patient to a psychiatrist for management of the psychiatric problems, he may do a briefer psychiatric evaluation. Decisions regarding continuing management of the patient can of course be made after consultation; such variables as those already mentioned (probable diagnosis, severity and urgency of the patient's condition) will enter into this decision of who should manage the patient. The indications for psychiatric referral and the importance of making the referral in such a way as to facilitate acceptance and to minimize the likelihood of the patient's feeling misunderstood or rejected are discussed in Part 17.

Goals

Comprehensive psychiatric diagnosis includes (1) delineation of symptomatic and functional problems, (2) identification of a psychiatric syndrome or disorder, (3) assessment of factors which contribute to etiology, and (4) assessment of personal assets and resources.

Delineation of Problems

By psychiatric problems we refer to symptomatic complaints and difficulties in functioning, or behavior which stems from mental or emotional disturbance. Psychiatric problems may be related to (1) difficulties in cognition such as disorientation, poor memory, delusions, concretistic thinking, and hallucinations; (2) disturbance of feeling or mood such as depression, elation, and anxiety; (3) disordered function and somatic complaints (without discernible organic basis) such as insomnia, fatigue, anorexia, impotence, and headache; and (4) patterns of maladaptive behavior such as repeated inability to get along with persons in authority. Occasionally, patients will consult the primary physician because of a difficulty in their present life situation. Of the aforementioned types of problems, probably the most commonly encountered presenting complaint seen by the primary physician is that of functional or somatic symptoms without organic basis. It is wise to keep in mind that occasionally a patient may use a physical symptom that has an organic cause as an admission ticket to see the physician about an emotional problem.

Frequently, in the course of the clinical investigation, a group of problems emerges as a recognizable clinical entity or psychiatric disorder. When this occurs, definitive treatment is aimed at alleviation of the disorder, such as depression, with the reasonable expectation that relief from associated problems such as insomnia, anorexia, or loss of sexual in-

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The following chapter has been selected by the Publisher from its book, *Practical Psychiatry in Medicine,* by John B. Imboden, MD, and John Chapman Urbaitis, MD, in the hope that it will have immediate usefulness to our readers.

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Table 1. Classification of Psychiatric Disorders

1. Mental retardation
2. Disorders associated with organic impairment of cerebral function
   - A. Organic brain syndromes
   - B. Organic conditions in which the chracteristic features of OBS are absent, eg, psychosis associated with amphetamine intoxication
3. Psychoses without presently known organic impairment of cerebral function
   - A. Schizophrenic disorders
   - B. Major affective disorders
     - Unipolar manic illness
     - Depressive illness
     - a. Primary
       - Unipolar
       - Bipolar
     - b. Secondary
4. Neuroses
5. Personality disorders
6. Sexual disorders
7. Alcoholism and drug dependence
8. Psychophysiologic disturbances
9. Transient situational disturbances

terest will be obtained as the depression improves. However, as crucial as treatment of the underlying disorder is, the management of symptomatic manifestations or problems is also important and sometimes must be initiated before a comprehensive diagnosis is established.

For example, the physician, upon discerning that the patient presents evidence of emotional disturbance, must decide whether the disturbance constitutes an emergency. If an emergency exists, a preliminary management plan must be instituted without delay even though comprehensive diagnosis is not yet established. Psychiatric emergencies are discussed in Part 7. Here it may simply be noted that a psychiatric emergency exists when the patient is experiencing acute, intense suffering requiring immediate attention or when his behavior, actual or potential, is alarming. Probably the most common example of the latter is seen in the patient who poses a serious suicidal risk.

In addition to emergency situations, there are many psychiatric problems which warrant specific management in addition to longer range, definitive treatment of the underlying disorder. Severe insomnia, for example, may not only be a symptom of depression (or some other condition) but may itself significantly contribute to the patient's feeling of fatigue and apprehension; for this reason, the physician may attempt to provide the depressed patient relief from this symptom while awaiting the patient's response to antidepressant medication. Similarly, the confusion and panic of delirium pose problems that require careful management while determination and treatment of the underlying causes of the condition are underway. Severe anorexia or refusal to eat calls for careful monitoring of the

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patient's nutritional status regardless of the underlying disorder.

Psychiatric Disorders

Psychiatric illness can be defined as being any condition in which there is suffering and disability resulting primarily from a disorder of thinking, feeling, or behavior. This definition clearly encompasses (1) the organic brain syndromes, (2) the psychoses, (3) the neuroses, (4) the psychophysiologic disorders, (5) painful or disabling situational disturbances, (6) alcoholism, and (7) drug dependence. There has been considerable disagreement about the inclusion of personality disorders in the general rubric of psychiatric illness. However, there is little doubt that in some instances the enduring maladaptive attitudes and behavior of personality disorders do result in disability and suffering.

Table 1 gives a classification of the major psychiatric disorders; each (with the exception of mental retardation) is discussed elsewhere. Here we will only briefly describe some of the salient features which are useful in differentiating between several of the major categories of psychiatric illness. In arriving at a diagnosis, the clinician will find it practical to approach diagnostic categorization by proceeding from the broad categories to more restricted ones, and finally to specific entities.

The first categorization is to distinguish organic disorders from functional disorders. Here the clinician must be alert not only to evidences of the organic brain syndromes but also to organic diseases, such as hyperthyroidism, which can simulate emotional disorders. Organic brain syndromes (OBS) are characterized by impairment of orientation, memory, judgment, and other intellectual functions, such as comprehension and calculation; lability and shallowness of affect are often present. Nevertheless, psychoses caused by toxic substances are not invariably accompanied by these classic symptoms of OBS; a notable example is the psychosis associated with amphetamine intoxication which closely resembles acute paranoid schizophrenia and in which the sensorium is usually clear.

If organic causes seem unlikely, the next step is to distinguish between the functional psychoses (schizophrenia and affective disorders) and the nonpsychotic disorders (neuroses, personality disorders, and situational reactions). The term functional psychoses refers to those disorders which, in fully developed form, gravely impair mental functioning, grossly interfere with the patient's ability to cope with the ordinary demands of life, and for which, at the present time, no physical etiology has been definitely identified. The two main categories of functional psychoses are the schizophrenic disorders and the major affective disorders.

Schizophrenia includes a group of disorders manifested by misinterpretation of reality, interference with thought associations (blocking, concrete thinking, etc), delusions, hallucinations, marked ambivalence, flatness or inappropriateness of affect, withdrawal, and regressive or bizarre behavior; the sensorium is clear. The major affective disorders are characterized by depression or mania or, alternatingly, both. Depression is characterized by feelings of sadness, guilt, and hopelessness, decrease in interest in and ability to experience pleasure, attitudes of self-deprecation and pessimism, fatigue, psychomotor retardation, insomnia, poor appetite, weight loss, and a variety of somatic symptoms. Mania is characterized by an elated mood or irritability, hypertalkativeness, and hyperactivity. In schizophrenia and the affective disorders, the severity and variety of symptoms are reduced considerably during the incipient stage or convalescent stage of the illness; at these stages, or in other less than fully developed forms of the disorder, the illness may not have reached psychotic proportions.

The neuroses are characterized by (1) symptoms of anxiety such as fear, tenseness, palpitations, and sweaty palms; (2) symptoms which serve partially to alleviate or localize anxiety such as phobias, obsessions, compulsions, hypochondriasis, and conversion; or (3) both overt anxiety and anxiety-related symptoms. There is no evidence of disorientation or other impairment of intellectual function, nor is there evidence of distortions of reality recognition or of perception, and the patient is usually clearly aware that he has an emotional or psychologic disturbance.

Psychophysiologic disorders are characterized by physical symptoms accompanying physiologic changes produced by emotional factors. The hyperventilation syndrome is an example.

Alcoholism and drug dependence refer to conditions in which alcohol or drug consumption is damaging to physical health, inter-

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feres with personal and social functioning, or is associated with psychologic or physical dependence.

Situational disturbances refer to disorders which develop as a response to severe environmental stress and which abate when the stress is removed. This diagnosis is usually reserved for persons in whom there is no evidence of preexisting mental or emotional disorder.

Personality disorders are characterized by deeply ingrained maladaptive attitudes and patterns of behavior which often become manifest in adolescence or earlier; there is relatively little evidence of overt anxiety or other neurotic symptoms.

It is apparent that these categories of illness are not mutually exclusive. Patients with schizophrenic illness, depression, neurosis, or personality disorder may become dependent upon drugs or alcohol and are not immune to the development of organic brain syndromes. Organic disease affecting cerebral function may precipitate a depression, severe anxiety, or paranoid delusions, or may exacerbate an already existing emotional disorder.

Assessment of Etiologic Factors

Modern medical practitioners have long desired to aim treatment at the cause or causes of illness and not to rest content with symptom alleviation alone. Further, it has become increasingly apparent that the concept of a simple one-to-one relationship between a single cause and a single effect (disease) does not apply to most types of illness; clearly, it does not apply to psychiatric disorders. In considering the etiology of psychiatric disorders it is helpful to bear two concepts in mind: (1) most (perhaps all) psychiatric disorders result from the convergence of more than one etiologic factor; and (2) psychiatric disorders unfold in an epigenetic manner, ie, what has already developed partially determines what is to be developed. Thus, the clinician is interested in ascertaining those factors which were present at the time of onset or exacerbation of the illness, in understanding the epigenetic sequence of illness development, and, where possible, in applying his grasp of etiology to the planning of treatment and management.

The process of diagnostic categorization discussed above yields some knowledge of etiology and serves to direct the clinican along certain lines of investigation. This is clearly the case, for example, when the intermediate diagnosis is organic brain syndrome or when, even in the absence of the usual symptoms of OBS, the clinican suspects that a physical or toxic factor is present; the physician then begins a systematic inquiry into the possibilities with particular emphasis on the discernment of those contributory factors which can be removed or modified by treatment. In this example, the aim of the investigation is to narrow the diagnosis to an etiologically specific type of OBS, such as toxic psychosis secondary to barbiturate withdrawal, and then to plan management accordingly.

In the example of toxic psychosis secondary to barbiturate withdrawal, the immediate precipitating event is, of course, the cessation of barbiturate ingestion. The epigenetic sequence which preceded the toxic psychosis includes (1) those psychologic, social, and other factors which led the patient to "need" or want hypnotic drugs; and (2) the actual ingestion of barbiturates in sufficient amount and for a sufficient period of time to establish physical dependence. Obviously, the investigation of the factors which contributed to the establishment of the addiction requires the collaboration of the patient (and often his family), and is crucial to the planning of long-range treatment aimed at assisting the patient with underlying emotional problems and at preventing a recurrence of the addiction.

The contributory factors in emotional disorders include (1) hereditary predisposition; (2) pre-illness personality development and adaptation; (3) life situation around the onset, remission, and exacerbation of illness episodes; and (4) present life situation.

For example, the clinician may learn that the depressive illness of a middle-aged woman began around the time her youngest child married and left home (the "empty-nest syndrome"). The physician knows that most women do not become clinically depressed by such an event in their lives. What is there about the patient that apparently predisposed her to react to that event with depression? A number of contributory factors might be ascertained upon further investigation. Not uncommonly it is learned that the patient has long led a rather narrow, constricted life, deriving her feeling of worthwhileness almost entirely from her role as mother, and that a certain distance between the patient and her husband has slowly developed over a

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