Classification of mental disorders

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Purpose of Diagnosis in Psychiatry

- 1. Order and Structure
- 2. Communication
- 3. Predict Outcome
- 4. Decide Appropriate Treatment
- 5. Research: Assist in the search for pathophysiology and etiology

Procedural considerations for Assessment

- Classification and diagnosis usually follow clinical interviewing to determine diagnosis
 - A diagnostic interview is the most widely used assessment tool in clinical psychiatry.

Assessments

Psychological:

- Clinical interviews and reports
- Tests (psychological incl. neuropsychological)

Biological:

- Scanning brain function (e.g. CT, CT, MRI, fMRI, EEG, PET)
- Neurochemical
- Genetic
- Psychohysiological measures

Components of Psychiatric Assessment

- Identifying data
- Chief Complaint
- History of Present Illness
- Past Psychiatric History
- Past Medical History
- Family History
- Social History
- Mental Status Exam
- Assessment: Main diagnosis and comorbidities (psychiatric and somatic)

Mental status examination incl.

- General appearance
- Consciousness
- Orientation
- Speech and thought (speed, content)
- Perception
- Mood
- Anxiety
- Attention/concentration
- Memory
- Insight and judgement
- Intelligence/higher intellectual functioning
- Suicidality

General Appearance and Behavior

- Describe appearance/behavior
- Grooming, hygiene, facial expressions
- Jewelry, tattoos,
- Attitude towards examiner
- Does pt look stated age?

Psychomotor Activity

- Posture
- Describe motor activity
- Does s/he seat quietly or agitated?
- Note abnormal movements
 - Tics
 - EPS (extrapyramidal symptoms)
 - mannerisms
 - catatonia
 - TD (tardive dyskinesia)

Speech

- Note patient's speech
 - RRR (regular in rate and rhythm)
 - Pressured, slow, normal
 - Loud, soft
 - Poverty of speech/content of speech
 - Latent
 - Echolalia
 - Aphasia

Thought Form

- Describe thought process—this is inferred by pattern of speech
 - Slow vs. fast
 - Logical and goal directed
 - Concrete
 - Preservative
 - Circumstantial, tangential
 - Thought blocking

Thought Content

- Describe Content of Thought
 - Delusions
 - Ideas of Reference
 - Obsessions and Compulsions
 - Phobia
 - Distorted body image
 - Poverty of content
 - Passive death wish
 - Suicidal/Self Harm/Homicidal Ideation

Mood

- Mood is an emotional attitude that is relatively sustained (based on patient's report)
 - Euthymic
 - Depressed
 - Hyperthymic (English: euphoric however "phoria" is not aequivalent to "thymia". Which is mood!)
 - Irritable (mixed states suicidality!)

Affect

- Affect refers to way pt conveys her/his emotional state (based on observation)
 - Appropriate vs inappropriate
 - Full
 - blunted
 - flat

Sensorium and Cognition 1.

- Mini Mental Status Exam covers most of the components
- Describe level of alertness
- Orientation (time, space, self and others)
- Memory
 - Very short term: repeat 3 items
 - Short term: recall 3 items
 - Long term: events that occurred in past

Sensorium and Cognitive Function 2.

- General Information
 - List 5 past presidents, current events
- Calculations
- Serial 7's vs 3's, spell WORLD backwards
- Capacity to Read and Write
- Read text, write a sentence
- Visuospatial Ability
 - Copy design
- Proverbs

Insight and Judgment

- Insight: does the patient understand her/his illness, the need for treatment?
- Judgment: does the person make good choices?

PANSS: Positive and Negative Syndrome Scale

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PANSS RATING FORM

| | | absent | minimal | mild | moderate | moderate severe | SEVERE | extreme |
|-----|---|--------|---------|------|----------|--------------------|--------|---------|
| Pl | Delusions | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| P2 | Conceptual disorganisation | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| P3 | Hallucinatory behaviour | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| P4 | Excitement | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| P5 | Grandiosity | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| P6 | Suspiciousness/persecution | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| P7 | Hostility | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| N1 | Blunted affect | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| N2 | Emotional withdrawal | | 2 | 3 | 4 | | 6 | 7 |
| N3 | Poor rapport | | 2 | 3 | | 5 | 6 | 7 |
| N4 | Passive/apathetic social withdrawal | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| N5 | Difficulty in abstract thinking | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| N6 | Lack of spontaneity & flow of conversation | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| N7 | Stereotyped thinking | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| G1 | Somatic concern | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| G2 | | | | | | - | - | |
| G3 | Anxiety | 1 | 2 | 3 | | 5 | 6 | 7 |
| G4 | Guilt feelings Tension | : | 2 | 3 | - : | | | 7 |
| G5 | Mannerisms & posturing | | 2 | 3 | 7 | 5 | | 7 |
| G6 | Depression | | 2 | 3 | | | | , |
| G7 | Motor retardation | | 2 | 3 | 7 | | 6 | 7 |
| G8 | Uncooperativeness | - 1 | 2 | 3 | 1 | | 6 | 7 |
| G9 | Unusual thought content | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| G10 | Disorientation | 1 | 2 | 3 | 4 | | 6 | 7 |
| G11 | Poor attention | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| G12 | Lack of judgement & insight | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| G13 | Disturbance of volition | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| G14 | Poor impulse control | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| G15 | Preoccupation | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| G16 | Active social avoidance | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

PANSS: Positive and Negative Syndrome Scale

http://egret.psychol.cam.ac.uk/medicine/scales/PANSS

The Mini Mental State Examination (MMSE)

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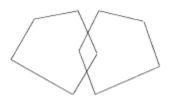
The Hartford Institute for Geriatric Nursing, Division of Nursing, New York University is cited as the source.

Available on the internet at www.hartfordign.org. E-mail notification of usage to: hartford.ign@nyu.edu.

MMSE (2)

Copy the design shown.

Total Score
ASSESS level of consciousness along a continuum ______
Alert Drowsy Stupor Coma



Clock test

Please draw a clock which shows quarter to 3.

Diagnostic Manuals

 Diagnostic and Statistical Manual of Mental Disorders, (5th Edition 2013) – DSM-5, American Psychiatric Association

 International Statistical Classification of Diseases, Injuries and Causes of Death (10th version - 1993) – ICD-10, World Health Organization

History of DSM

- DSM I (1952)
 - established mainly by psychoanalysts to distinguish groups of psychoneurotic disorders, such as anxiety.
 - Interpretations of psychoneurotic disorders were mainstream Freudian (defense mechanisms).
 - Discourses of 'reactions' predominated.

DSM II (1968)

- 1950's 1960's psychoanalysis still dominated.
 Psychoneurotic problems became defined as 'neurotic' disturbances (e.g. hysteria)
- In 1973, homosexuality was removed, replaced by 'sexual orientation disturbance'
- There was little in the way of clear descriptions of 'disorders'. All 'symptoms' were defined as 'symbolic' (of unconscious processes)

DSM III (1980)

- Completely new directions in psychiatry instead of symptoms defined as 'symbols' - they were viewed as natural disease categories
- Return to the world of medicine
- Aims: research driven; operational criteria; based on 'symptoms' check list, not symbolic gestures
- Outcome: the production of a science driven document – ego-dystonic homosexuality still included
- Translated into many languages

ICD - 11 in 2018?

http://apps.who.int/classifications/icd11/browse/f/en

BNO - 11

- Schizophrenia or other primary psychotic disorders
 - 6A50 Schizophrenia
 - 6A50.1 Schizophrenia, first episode
 6A50.11 Schizophrenia, first episode,
 currently symptomatic
 6A50.12 Schizophrenia, first episode, in
 partial remission
 6A50.13 Schizophrenia, first episode, in full
 remission
 6A50.1Z Schizophrenia, first episode,
 - ▶ 6A50.2 Schizophrenia, multiple episodes
 - 6A50.3 Schizophrenia, continuous
 6A50.Y Other specified schizophrenia
 6A50.Z Schizophrenia, unspecified
 - ▶ 6A51 Schizoaffective disorder

unspecified

6A52 Schizotypal disorder

- ▶ 6A53 Acute or transient psychotic disorder
- 6A54 Delusional disorder
 6A5Y Other specified schizophrenia or other primary psychotic disorders
 6A5Z Schizophrenia or other primary psychotic disorders, unspecified

BNO - 11

Associated with (use additional code, if desired)

If desired, you could provide additional specific detail.

| MC80 | Positive symptoms in primary psychotic disorders |
|------|--|
| MC81 | Negative symptoms in primary psychotic disorders |
| MC82 | Depressive symptoms in primary psychotic disorders |
| MC83 | Manic symptoms in primary psychotic disorders |
| MC84 | Psychomotor symptoms in psychotic disorders |
| MC85 | Cognitive symptoms in primary psychotic disorders |
| | |

DSM-III Paradigm Shift

- Descriptive
- Non-etiologic focus
- Diagnostic criteria
- Multiaxial system
- Multiple diagnoses (increase in comorbidities)
- Reliability

DSM III R (1987)

- + self-defeating personality disorders
- Post-traumatic stress disorder was introduced to account for repeated trauma in Vietnam veterans
- Pressure groups altered the course of the DSM – ego-dystonic homosexuality removed

DSM IV (1994)

 Neurosis as a term is no longer in existence

- Mental disorders included
 - DSM II = 85 disorders
 - DSM III = 265 disorders
 - DSM III-R = 292 disorders
 - DSM IV = 297 disorders

DSM-IV TR, 2000

Minor changes

DSM-IV: Multi-Axial Classification System

- Axis I lists the majority of mental disorders.
- Axis II is reserved for persistent or chronic conditions (e.g. personality disorders)
 - The separation was intended to assure that more chronic conditions are not overlooked.
- Axis III is designed to present general medical information

DSM-IV: Multi-Axial Classification System

- Axis IV is designed to present specific information about the client's current psychosocial environment.
 - A number of global categories of problems are suggested in the DSM text.
 - Practitioners are encouraged to include specific information on Axis IV in addition to such global characterizations.

Multi-Axial Classification System

- Global Assessment Functioning (GAF) score is listed on Axis V.
 - This 100-point scale is presented in DSM-IV.
 - In some situations, an individual's functioning can be at very different levels depending on which aspect is emphasized.
 - It is recommended that in those instances, the client's potential for danger to self or others should take precedence in determining the GAF score.

Global Assessment of Functioning Scale GAF – DSM IV

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GLOBAL ASSESSMENT OF FUNCTIONING (GAF) SCALE DSM-IV

Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health-illness. Do not include impairment in functioning due to physical or environmental limitations.

Code Note: Use intermediate codes when appropriate. e.g., 45, 68, 72)

- 100-91 Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.
- 90-81 Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members)
- 80-71 If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument), no more than slight impairment in social, occupational, or school functioning (e.g., temporarily falling behind in schoolwork).
- 70-61 Some mild symptoms (e.g., depressed mood and mild insomnia) OR some difficulty in social, occupational, or school functioning (e.g., occasional truancy or theft within household), but generally functioning pretty well, has some meaningful interpersonal relationships.

To be eligible for TBOS, client must score 60 or below

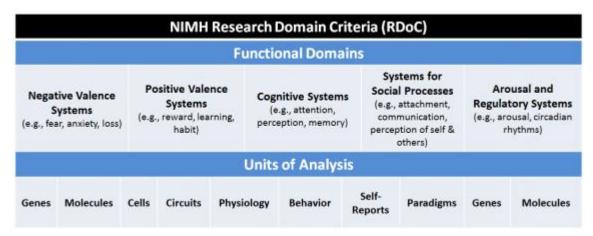
- 60-51 Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers).
- 50-41 Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).
- 40-31 Some impairment in reality testing or communication (e.g., speech is sometimes illogical, obscure, or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).
- 30-21 Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day; no job, home, or friends).
- 20-11 Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g., smears feces) OR gross impairment in communication (e.g., largely incoherent or mute).
 - Persistent danger of severely hutting self or others (e.g., recurrent violence) OR persistent
 inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of
 death.

DSM-5, 2013

- Controversies about both the process of creating DSM-5 and about its content as well.
- Two out of the major challengers:
 - 1. Thomas Insel, Director of the National Institute of Mental Health
 - 2. Allan Frances, Chair of the DSM-IV Task
 Force of the American Psychiatric Association

Reseach Domain Criteria (RDoC) Thomas Insel, Former director of NIMH*



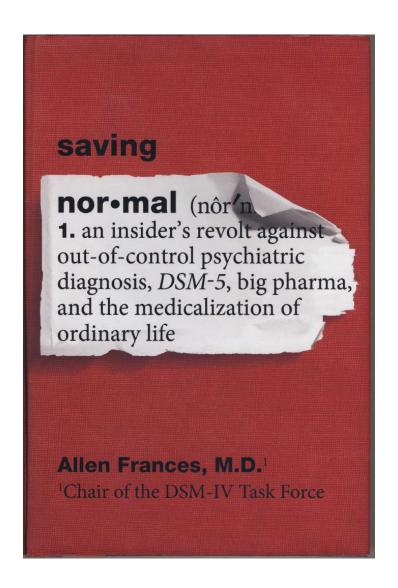


http://www.behavioral.net/sites/behavioral.net/files/imagecache/570x360/RDoC2.PNG

* This year Thomas Insel announced his decision to move to Google

Too Loose criteria?





Parts of a psychiatric disorder definition

1. Symptoms

- 2. **Time** onset (e.g. ADHD: before age 12) and/or length (e.g. major depressive episode: min 2 weeks)
- 3. Significant distress and/or impairment in social, occupational or other important areas of functioning.
- 4. Exclusion criteria (substance or an other medical condition)

Reliability and Validity

Reliability

- Consistent diagnoses
- Interrater reliability
- Clear methods of assessment, standardised symptoms

Validity

- Construct validity
- Etiological Validity: Consistent Causal Factors
- Predictive Validity: Successful prognosis most people with bipolar respond well to lithium carbonate, suggesting coherence in diagnostic group

DSM and ICD

- Advantages
- 1. Improve reliability of dx
- Clarify dx and facilitate history taking
- Clarify and facilitate process of differential diagnosis

Disadvantages

- 1. False sense of certainty
- 2. May sacrifice **validity** for reliability

RELIABILITY: capacity of individuals to agree

VALIDITY: capacity to make useful predictions

3. Treat dx like checklist and forget about patient as a person