This is the only advanced practice guide to provide an overview of the major DSM disorders across the life span along with complete clinical guidelines for their diagnosis, treatment options, and psychopharmacologic management. It has been compiled by expert practitioners in psychiatric care and is designed for use by nurse practitioners and other primary caregivers in clinical practice. The guide is organized in an easy-to-access, bullet format. The first two sections provide an overview of the principles of clinical psychiatry (interview, clinical decision making, diagnostic evaluation, and treatment planning), psychotherapeutic management (including behavioral therapy and cognitive behavioral therapy), the principles of psychopharmacology (neurotransmitters, receptors, neuroanatomy, pharmacokinetics, and pharmacodynamics). The third and fourth sections present syndromes and treatment in adult psychiatry and child and adolescent psychiatry. The last section presents nearly 90 drug monographs representing disorders for which drugs can play a significant therapeutic role.

Each disorder chapter includes clinical features and symptoms of the disorder, as well as information about the most current drugs and adjunctive therapies for effective management. Life span considerations and precautions are presented for pediatrics, geriatrics, patients with compromised kidney and liver function, and pregnant patients.

To aid in appropriate drug selection, each disorder chapter includes a Drug Selection Table identifying and prioritizing the first and second lines of drug therapy according to drug classification when drugs can play a significant therapeutic role in clinical management of a disorder.

The drug monographs included in the last section are consistently organized by brand and generic names, drug class, customary dosage, side effects, drug interactions, pharmacokinetics, precautions, and management of special populations. Convenient, practical, and portable, this guide will be a welcome and frequently used resource. Suggested readings or additional resources in each chapter provide an opportunity for more in-depth study.

Key Features:

• Presents treatment guidelines for major DSM disorders across the life span, including biobehavioral interventions and psychopharmacological interventions with parameters for use of each drug
• Drug selection tables prioritize drugs according to their clinical efficacy and recommended treatment algorithms
• Includes brand and generic names, customary dosages, side effects, drug interactions, pharmacokinetics, precautions, patient teaching, and management of special populations
• Provides guidelines for use in special populations, including older patients, pediatric patients, pregnant patients, and patients with impaired kidney and liver function
• Offers information on clinical algorithms, lab evaluation, and preventive services

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11 W. 42nd Street
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Clinical Consult to Psychiatric Nursing for Advanced Practice
Jacqueline Rhoads, PhD, APRN-BC, CNL-BC, PMHNP-BE, FAANP, is a professor of nursing at University of Texas Medical Branch at Galveston School of Nursing, and has held many faculty positions during her career. She has taught in nurse practitioner (NP) programs since 1994. She has been awarded major research funding for a variety of research projects and continues to foster an evidence-based practice implementing outcomes-focused care. Dr. Rhoads earned her PhD from the University of Texas, Austin, and has earned post-master’s degrees in acute care NP, community health primary care adult NP, gerontology NP, and psychiatric/mental health NP, and recently earned her clinical nurse leader certification. She is a fellow in the American Academy of Nurse Practitioners, and was awarded numerous commendations and medals for meritorious service in the U.S. Army Nurse Corps. Dr. Rhoads has authored three books for major nursing publishers as well as numerous articles. Her recent publication, *Nurses’ Clinical Consult to Psychopharmacology*, won first place as AJN Book of the Year Award, 2012. Her textbook, *Clinical Consult to Psychiatric Mental Health Care*, won second place as AJN Book of the Year Award in 2011.

Patrick J. M. Murphy, PhD, is an assistant professor at the Seattle University College of Nursing, where he teaches introduction to pharmacology (Bachelor of Science in Nursing students), and advanced pharmacological application in primary care and psychopharmacology in advanced practice nursing (Master’s of Science in Nursing/nurse practitioner students), among other courses. He holds an MS and PhD in pharmacology from the University of Michigan. He has served as the scholar-in-residence, Hope Heart Institute (Seattle, Washington), and as a visiting scientist at Fred Hutchinson Cancer Research Center, also in Seattle. Previously, he served as a research fellow, University of Michigan Medical School, and guest lecturer, University of Michigan School of Nursing. He has published 22 peer-reviewed journal articles and multiple book chapters, as well as having presented 15 podium presentations and numerous invitational lectures. He is the co- or the primary investigator on six funded research projects. Dr. Murphy is the recipient of multiple honors and awards, notably the Outstanding Teacher of the Year Award (2009, Seattle University), Outstanding Graduate Student Teaching Award (2001, University of Michigan Medical School), and a Horace H. Rackham Fellowship from the University of Michigan Graduate School. He is a member of the Phi Sigma Tau Academic Honorary Society and the Phi Eta Sigma Academic Honorary Society.
Clinical Consult to Psychiatric Nursing for Advanced Practice

Jacqueline Rhoads, PhD, APRN-BC, CNL-BC, PMHNP-BE, FAANP

Patrick J. M. Murphy, PhD

Consultants

Tammie Lee Demler, BS, PharmD, MBA, BCPP
Sandra J. Wiggins Petersen, DNP, FNP, GNP-BC
This book is dedicated to all those suffering from a mental health disorder and to those who care for them.
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Athena J. Arthur, MS, LCDC  
Doctoral Student  
Fielding Graduate University  
Santa Barbara, California

Renee R. Azzouz, ARNP  
Overland Park, Kansas

Sandra S. Bauman, PhD, ARNP, LMHC  
Lecturer  
School of Nursing and Health Studies  
University of Miami School  
Coral Gables, Florida

Virginia Brooke, RN, PhD  
University of Texas Medical Branch  
Medical School  
Galveston, Texas

Deonne J. Brown-Benedict, DNP, ARNP, FNP-BC  
Assistant Professor and Family  
Nurse Practitioner Track Clinical Coordinator  
College of Nursing  
Seattle University  
Seattle, Washington

Angela Chia-Chen Chen, PhD, RN  
Assistant Professor  
College of Nursing and Health Innovation  
Arizona State University  
Phoenix, Arizona

Lawrence S. Dilks, PhD  
Clinical Neuropsychologist  
Lake Charles, Louisiana

Susan O. Edionwe, MD  
University of Texas Medical Branch Medical School  
Galveston, Texas

Elizabeth Hite Erwin, PhD, APRN-BC  
Assistant Professor  
School of Nursing  
University of Virginia  
Charlottesville, Virginia

Deborah Gilbert-Palmer, EdD, FNP-BC  
Associate Professor of Nursing and FNP Program Coordinator  
Department of Nursing  
Arkansas State University  
State University, Arizona

Nnenna I. Igbo, MD  
University of Texas Medical Branch Medical School  
Galveston, Texas

Jose Levy, MA, BCBA, CBIST  
Fielding Graduate University  
Austin, Texas

Jo-Ann Summitt Marrs, EdD, FNP-BC  
East Tennessee State University  
Johnson City, Tennessee

Patrick J. M. Murphy, PhD  
College of Nursing  
Seattle University  
Seattle, Washington

© Springer Publishing Company
Meena Patel, ARNP, DNP (Candidate)
Overland Park, Kansas

Nancy Pierce, ARNP
Psychiatric and Counseling Associates
Leawood, Kansas

Theresa Raphael-Grimm, PhD, RN, CS
University of North Carolina
Chapel Hill, North Carolina

Jacqueline Rhoads, PhD, ACNP-BC, ANP-C, CNL-BC, PMHNP-BE, FAANP
Professor of Nursing
University of Texas at Galveston Health Science Center School of Nursing
Galveston, Texas

Judy Rice, BSN, MSN FNPCS
Johnson City, Tennessee

Victoria Soltis-Jarrett, PhD, PMHCNS/ NP-BC
Clinical Associate Professor and Coordinator
University of North Carolina
Chapel Hill, North Carolina

Kimberly Swanson, PhD
Research Interventionalist
University of Washington School of Social Work
Seattle, Washington

Hisn-Yi (Jean) Tang, PhD, APRN
Assistant Professor
College of Nursing
Seattle University
Seattle, Washington

Kristen Vandenberg, MSN, ARNP, FNP-BC
University of North Florida
Jacksonville, Florida

Alma Vega, EdD, MSN, ARNP-BC
Assistant Professor
School of Nursing and Health Studies
University of Miami
Coral Gables, Florida

Lucinda Whitney, MSN, ARNP-BC
Overland Park, Kansas

Elizabeth Willford
University of Texas Medical Branch Medical School
Galveston, Texas

Contributors to Nurses’ Clinical Consult to Psychopharmacology

Sandra S. Bauman, PhD, ARNP, LMHC
Lecturer
School of Nursing and Health Studies
University of Miami School
Coral Gables, Florida

Deonne J. Brown-Benedict, DNP, ARNP, FNP-BC
Assistant Professor
Family Nurse Practitioner Track Clinical Coordinator
Seattle University College of Nursing
Seattle, Washington

Angela Chia-Chen Chen, PhD, RN, PMHNP-BC
Assistant Professor
Arizona State University
College of Nursing and Healthcare Innovation
Phoenix, Arizona

Karen Crowley, DNP, APRN-BC, WHNP, ANP
Assistant Professor
Regis College
School of Nursing, Sciences and Health Professionals
Weston, Massachusetts

Deborah Gilbert-Palmer, EdD, FNP-BC
Associate Professor
Arkansas State University
State University, Arkansas

Lori S. Ireelan, FNP, APRN, MSN
Wilmington University
New Castle, Delaware

Mitsi H. Lizer, PharmD, BCPP, CGP
Associate Professor Pharmacy Practice, Shenandoah University School of Pharmacy
Winchester, Virginia

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The devastation of the Gulf Coast after Hurricane Katrina has been imprinted in our memories not only by the sensational news coverage but also by the personal experiences of many health care providers who volunteered countless hours in helping the people affected by this disaster. I was one of the providers who responded. From that experience came a realization of how many people were and are affected by mental illness, and how little I knew of the protocols that could be used to provide mental health care to those I served. I went back to school for my post-master’s degree in psychiatric mental health and saw the lack of published information that would lend assistance to those caring for people with mental disorders.

As a result of this realization, the Clinical Consult to Psychiatric Mental Health Care was published in October 2010, and provides “what to do next” guidelines when working with and beginning the treatment of a patient with a mental health disorder. But this was only the first step: the next step was to publish the Nurses’ Clinical Consult to Psychopharmacology in January 2012. This important psychopharmacology reference is customized to reflect particular prescribing and management considerations for a wide range of psychiatric disorders. These two resources together provide evidence-based guidelines to consider when assessing and caring for persons with a mental health disorder.

Now, these two essential clinical references are combined into one “complete” clinical resource for use by nurse practitioners and others caring for patients in clinical practice. Compiled by expert practitioners in psychiatric care, this work provides an overview of the management of the major Diagnostic and Statistical Manual of Mental Disorders, fifth edition (American Psychiatric Association, 2013) disorders across the life span and delivers complete clinical guidelines for their diagnosis, treatment options, and psychopharmacologic management.

We have constructed each chapter using a bullet format for quick reference within a structured approach. This reference is organized into two major sections: The first is the overview of the principles of clinical psychiatry (interview, clinical decision making, diagnostic evaluation, and treatment planning), psychotherapeutic management, behavioral therapy and cognitive behavioral therapy, and the principles of psychopharmacology (neurotransmitters, receptors, neuroanatomy, pharmacokinetics, and pharmacodynamics), and syndromes and treatment in adult psychiatry and syndromes and treatment in child and adolescent psychiatry. The second section presents nearly 90 monographs representing current major drug therapies for the major disorders that benefit from drug intervention.
A clinically useful drug selection table appears with each disorder for which psychopharmacology is an appropriate intervention and identifies the first and second line of drug therapy along with adjunctive therapies. It is important to note that the order in which drugs are listed within the drug classification on the drug table is significant in helping to guide drug choice. Additionally, it is important to note that not every drug within a classification is included for all disorders; rather, drugs that have been shown to have clinical efficacy are listed in a priority fashion to help guide the drug choice by the prescriber.

Essential drug information that is needed to safely prescribe and monitor the patient’s response to those drugs includes the following: drug name, brand name, and generic name; drug class, usual and customary dosage, and administration of the drug; availability (e.g., as tablet, injection, intravenous, capsule); side effect, drug interaction, pharmacokinetics, precautions; patient education; and special populations. The special populations section includes management of those who are pregnant, breastfeeding, older adults, children, adolescents, and patients with impaired renal, hepatic, or cardiac function.

The book provides a concise, complete, easy-to-access clinical resource so the primary care provider can quickly access the following:

- Diagnostic criteria and differential diagnoses for each disorder
- The range of therapeutic interventions useful for managing disorders, including psychotherapeutic management, psychotherapy, and cognitive behavioral therapy
- The overarching principles of pharmacodynamics and pharmacokinetics to consider when prescribing a drug
- The main psychotropic medications, when to prescribe, and how to select the most efficacious drug for each patient
- Special considerations for patient populations, including older adults, those who are pregnant, breastfeeding, children, and adolescents
- Clinical considerations for prescribing in patients with impairment of renal, hepatic, and/or cardiac function
- Easy-to-read drug-selection tables for reliable clinical consultation
- Extensive references for further reading

Pharmacology knowledge and applied clinical practices are constantly evolving due to new research and applied science, which expand our diagnostic capabilities and treatments. Therefore, it must be emphasized that practitioners carry an important responsibility to ensure that the treatment they select reflects current research and is appropriate according to manufacturer drug information for drugs selected; that dosages, route of administration, effects/precautions have been taken into consideration; and also that interactions and use in special populations are all accurate and appropriate for each patient. The practitioner is ultimately responsible to know each patient’s history, to have conducted a thorough physical examination, and to consult appropriate diagnostic test results so as to ascertain best possible pharmacotherapeutic actions for optimal patient outcomes and appropriate safety procedures.

The contributors to this text have worked hard to present current and applicable content that is of therapeutic value in the understanding of specific mental health disorders. We are very grateful to the contributors of this text for their hard work and focused support.

*Jacqueline Rhoads
Patrick J. M. Murphy*
I wish to acknowledge several individuals for the help and support they provided in the creation of this book. First to Joanne Jay, vice president of production, at Springer. Her dedication and work on this book and its publication made the book possible.

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Jacqueline Rhoads
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Part I

General Psychiatry
Chapter 1
The Psychiatric Interview and Diagnosis

INTRODUCTION

- The psychiatric interview is the core of proper psychiatric evaluation. It plays an important role not only in clinical assessment but also in therapy. The interviewer should come to understand the patient’s behaviors, emotions, experiences, and psychological, social, religious influences, and motivations through verbal and nonverbal communication with the patient.
- The psychiatric interview can be divided into the following stages: building an alliance with the patient, psychiatric history, diagnostic evaluation, and treatment plan formulation.
- As with all interviews, the patient–provider relationship is very important. An intact relationship between the interviewer and the patient increases the patient’s confidence and willingness to disclose the personal or sensitive information necessary for diagnosis and facilitates patient compliance.
- The psychiatric interview depends on more than verbal communication; it requires that the physician be observant and listen. Nonverbal communication can provide insight necessary for the patient’s clinical assessment and diagnosis, especially in patients significantly impaired by psychiatric disease.
- The extent of psychiatric impairment may necessitate that the interviews occur in multiple sessions or depend on information from additional persons such as family members or friends.
- The interview should begin with an open-ended approach.
- A structured interview approach combines the psychiatric interview with diagnostic criteria in attempts to derive a thorough psychiatric history.
The Patient–Provider Relationship: Building an Alliance

The patient–provider relationship is fundamental to providing excellent care, improving patient outcomes, and the healing process. It has special significance in psychiatry, where the “stigma” of psychiatric treatment can make even seeking treatment difficult.

A solid patient–clinician relationship requires optimization of the following seven components:
- Communication
- Office experience
- Hospital experience
- Patient education
- Integration (information sharing among all members of the treatment team)
- Shared decision making
- Outcomes

The patient–provider relationship involves a working or therapeutic alliance, which is an agreement between provider and patient, based on mutual rapport and trust, to undertake treatment together.

The interviewer must be sensitive to the importance of empathy, respect, and trust to develop a good working alliance.

Distrust is a common reason for noncompliance. In fact, most instances of noncompliance come from interruption of the provider–patient relationship.

The interviewer should develop a rapport with the patient:
- Remain attentive:
  - Maintain eye contact
  - Minimize distractions such as excessive note taking or interrupting the patient while speaking
- Be empathic:
  - Show the patient an understanding and appreciation for his or her situation.
  - Reinforce what the patient is feeling. One way to do this is by making statements such as, “I can see that was a very difficult time for you.”
- Listen! Listen! Listen!

The Interview: Nonverbal Communication

Active observation of the patient should occur within the first few minutes of the interview, before names have been exchanged and the “formal” interview has begun.

Actively process the patient’s nonverbal communication, such as the following:
- How does the patient first greet the interviewer?
- Does the patient make eye contact?
- What items (books or pictures, etc.) are present?
- What is the patient wearing and is his or her appearance disheveled or neat?
- What (if any) unusual sounds or smells are in the room?

Observation of the patient should continue throughout the interview. The interviewer should take note of the patient’s body language and emotional expressions during responses to the questions.

For example, a patient who becomes emotional when asked about a spouse may be depressed about a recent divorce or loss of a loved one.
Certain kinds of nonverbal communication are included in diagnostic criteria and the interviewer should be cognizant of their presence.

Active observation becomes increasingly important with increases in psychiatric impairments.

THE INTERVIEW: VERBAL COMMUNICATION

Open-ended questions
- After formally introducing yourself and your role in the patient’s care, start by asking open-ended questions.
- Examples of open-ended questions include the following:
  - Tell me what brings you here.
  - Tell me what kinds of problems you have had, lately.
- Three reasons why an open-ended manner of interviewing is important are as follows:
  - It strengthens the patient–provider relationship by showing that the interviewer is interested in the concerns of the patient.
  - It provides insight into the patient’s condition.
  - It allows the interviewer to understand what is most important to the patient rather than making assumptions.
- The interviewer should engage in active listening as the patient responds to questions.

Diagnosis-specific questions
- As the history develops, specific questions such as, “Do you see things that others cannot see?” (hallucinations) or “Have you ever tried to harm yourself?” (suicidal ideations) become necessary. Follow up on the responses.
- These specific questions aim at gathering information necessary for diagnosis based on Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5; American Psychiatric Association, 2013) criteria.
- The interviewer should be able to transition from open-ended questions to more specific ones.
  - For example, “Now I would like to ask you about several psychological symptoms that patients might experience.”

STRUCTURED INTERVIEWS

A structured interview uses a series of questions that couple the interview method with the DSM-5 diagnostic criteria in attempts to explore the signs and symptoms necessary for diagnosis.
- Examples include the following:
  - The MINI-International Neuropsychiatric Interview (MINI-Plus)
  - Structured Clinical Interview for DSM-5 disorders (SCID)
  - Composite International Diagnostic Interview (CIDI)
  - Schedules for Clinical Assessment in Neuropsychiatry (SCAN)

PSYCHIATRIC INTERVIEW ICD-10

- ICD-10 Code: Z046 (Z04.6) Code Type: Diagnosis
The Diagnostic Encounter

PHASES OF THE DIAGNOSTIC ENCOUNTER

The diagnostic encounter is divided into three phases:
- Opening phase
- Body of the interview
- Closing phase

Opening Phase
- Initial 5 to 10 minutes
- Goals
  - Introductions
  - Preinterview preparation
    - For example, ease patient’s fears or concerns about the necessity for the interview
  - Building a therapeutic alliance
  - Keeping questions open ended and allowing the patient to speak uninterrupted for an appropriate amount of time

Body of the Interview
- 30 to 45 minutes
- Goals
  - Psychiatric history
  - Diagnosis-specific questions such as, “Does this patient meet DSM-5 criteria for diagnosis?”
  - Mental status examination (MSE)
  - Physical examination
  - Additional investigations

Closing Phase
- 5 to 10 minutes
- Goals
  - Review your assessment with the patient
  - Collaborate with the patient on a treatment and follow-up plan

PSYCHIATRIC HISTORY

- Identifying data: collecting basic details about the patient, such as name, gender, age, religion, educational status, occupation, relationship status, and contact details.
- Chief complaint (CC): the reason for the patient’s presentation.
- History of present illness (HPI): the interviewer attempts to gain a clear understanding of the full history of the patient’s problems, such as when they started, what they entail, worsening symptoms, or associated symptoms. The HPI allows the interviewer to formulate preliminary hypotheses as to a diagnosis.
- Past medical history (PMH): the interviewer should explore the PMH to look for surgical or medical diseases or medications that cause, contribute to, or mimic psychiatric disease.
Past psychiatric history: explore previous diagnoses, treatments, and outcomes.

Family history (FH): explore familial psychiatric disorders or medical conditions as a cause of or contributing factors to psychiatric disorders.

Social history (SH): document the social circumstances of the patient, such as finances, housing, relationships, drug and alcohol use, and problems with the law, as these can contribute to the cause of psychiatric disease.

Development history: past, present, family, social, and cultural.

Review of systems (ROS): explore pertinent systems associated with the onset of psychiatric disease.

MENTAL STATUS EXAMINATION

Appearance: physique, grooming, dress, habits, nutritional status, posture, nervousness, and eye contact.

Attitude/rapport: attitude toward the examiner. For example, is the patient friendly, cooperative, bored, or defensive?

Mood: the patient’s emotions. Elicit by asking the patient questions such as, “How have you been feeling on most days?” List the mood in the patient’s own words. Moods include being depressed, angry, anxious, stressed, or elevated.

Affect: defined by the interviewer. Observable emotion: euthymic (normal), neutral, euphoric, dysphoric, or flat (no variation in emotion); the range: full, constricted, or blunted; appropriateness: appropriate or labile.

Speech: quality, quantity, rate, and volume.

Thought process: the organization of the patient’s thoughts

Logical: normal thought process

Loose associations: the patient slips off the track from one idea to an unrelated one.

Flight of ideas: verbally skipping from one idea to another before the previous one has been concluded

Tangentiality: the responses never approach the point of the questions.

Thought blocking: patient stops abruptly in the middle of a thought.

Circumstantiality: delay in getting to the point because of unnecessary details and irrelevant remarks

Neologism: patient creates new words.

Thought content

Suicidal ideation: assess plan and previous attempts

Homicidal ideation: assess plan and previous attempts

Obsessions and compulsions

Phobias

Paranoia

Perceptual disturbances

Hallucinations: perception of a stimulus in the absence of a stimulus; auditory (hearing things), visual (seeing things), olfactory (smelling things), tactile (feeling things), and gustatory (tasting things)

Delusions: grandiosity, religious delusion, persecution, jealousy, thought insertion (belief that someone is putting ideas or thoughts into his or her mind), ideas of reference (belief that irrelevant, unrelated phenomena in the world refer to him or her directly or have special personal significance)

Illusions: erroneous interpretation of a present stimulus

Insight: the patient’s understanding of his or her illness
Judgment: estimate the patient’s judgment on the basis of the history or on an imaginary scenario. Ask the following question: “What would you do if you smelled smoke in a crowded theater?” (adequate response is, “Call 911” or “Get help”; poor response is, “Do nothing” or “Watch the smoke rise”).

Impulsivity: the degree of the patient’s impulse control

Reliability: determine whether the patient seems reliable, unreliable, or if it is difficult to determine.

PHYSICAL EXAMINATION

Medical conditions (central nervous system [CNS] malignancy, hypothyroidism, or pancreatic cancer) can mimic a psychiatric illness. A thorough physical examination (usually except genitourinary examination), including full neurological examination, should be documented.

ADDITIONAL INVESTIGATIONS

- Lab investigations
- Additional information from accompanying friend or family members
- Other forms of pertinent information

Clinical Decision Making

The decision-making process has been broken down into a systematic and individualized process involving the following:

- State-mandated criteria: clinical practice guidelines, DSM-5, and so on.
- Investigation of alternatives: for example, ruling out medical conditions that mimic psychiatric disease through lab investigations
- Shared decision making: requires an adequate patient–clinician relationship
- Intuitive reasoning and experiences such as years of experience or exposure to previous psychiatric disorders
- Connection with the client, caution, and inability to control all contingencies

Strategies of clinical reasoning and decision making include the following:

- Tolerate uncertainty, avoid premature closure, and consider alternatives.
- Separate cue from inference; be able to refer inferences to the salient cues from which they were derived.
- Be aware of personal reactions to the patient.
- Be alert for fresh evidence, particularly evidence that demands a revision or deletion of a hypothesis or diagnosis.
- Value negative evidence above positive evidence.
- Be prepared to commit to a diagnosis when enough evidence has been gathered.

Historically, decision making has shown variability among practitioners. As a result, efforts have been made to create practice guidelines, processes, and recommendations that will result in consistency in the diagnostic evaluation and, subsequently, in the treatment of psychiatric disease.

Trend toward evidence-based clinical decision making:

- Use of DSM-5 guidelines
- Goals
More clinical research independent of pharmaceutical companies
An efficient means of making evidence-based data easily accessible to clinicians

**Diagnostic Formulation, Treatment Planning, and Modes of Treatment**

**PUTTING IT ALL TOGETHER: DIAGNOSTIC FORMULATION**

- Diagnostic formulation has been traditionally described as a summary of the relevant genetic, constitutional, and personality factors and their interaction with the etiological factors, taking into account the patient’s life situation, together with a provisional diagnosis.
- Essentially, the full encounter, including psychiatric history, MSE, labs, referral information, additional information from family members/friends, and physical examination, is assessed to yield a diagnosis.
- Currently, a diagnostic formulation is best accomplished using the *DSM-5* multi-axial system of assessment.

**DSM-5 DISORDERS AND ICD-10 CODES**

- These disorders will be listed as Axis I or Axis II on the multiaxial system assessment.
- **Adjustment disorders**
  - Adjustment Disorder Unspecified (F43.20)
  - Adjustment Disorder with Anxiety (F43.22)
  - Adjustment Disorder with Depressed Mood (F43.21)
  - Adjustment Disorder with Disturbance of Conduct (F43.24)
  - Adjustment Disorder with Mixed Anxiety and Depressed Mood (F43.23)
  - Adjustment Disorder with Mixed Disturbance of Emotions and Conduct (F43.25)
- **Anxiety disorders**
  - Acute Stress Disorder (F43.0)
  - Agoraphobia (without a history of Panic Disorder) (F40.02)
  - Generalized Anxiety Disorder (GAD; [F41.1])
  - Obsessive-Compulsive Disorder (OCD; [F42])
  - Panic Disorder—with Agoraphobia (F40.01) or without Agoraphobia (F41.0)
  - Social Phobia (F40.10)
  - Posttraumatic Stress Disorder (PTSD; [F43.1])
- **Dissociative disorders**
  - Dissociative Amnesia (F44.0)
  - Dissociative Fugue (F44.1)
  - Dissociative Identity (Multiple Personality) Disorder (F44.81)
  - Depersonalization-Derealization Syndrome (F48.1)
- **Eating disorders**
  - Anorexia Nervosa (F50.0)
  - Bulimia Nervosa (F50.2)
Impulse control disorders
- Intermittent Explosive Disorder (F63.81)
- Kleptomania (F63.2)
- Pathological Gambling (F63.0)

Mood disorders
- Bipolar Disorder (F31.0)
- Cyclothymic Disorder (F34.0)
- Dysthymic Disorder (F34.1)
- Major Depressive Disorder (F32.0)

Sexual disorders
- Exhibitionism (F65.2)
- Fetishism (F65.0)
- Frotteurism (F52.8)
- Pedophilia (F65.4)
- Sexual Masochism (F65.51)
- Sexual Sadism (F65.52)
- Transvestic Fetishism (F65.1)
- Voyeurism (F65.3)

Sleep disorders
- Primary Insomnia (F51.01)
- Primary Hypersomnia (F51.11)
- Narcolepsy (F47.4)
- Nightmare Disorder (F51.5)
- Sleep Terror Disorder (F51.4)
- Sleepwalking Disorder (F51.3)

Psychotic disorders
- Brief Psychotic Disorder (F23)
- Delusional Disorder (F22)
- Schizoaffective Disorder (F29.5)
- Schizophrenia
  - Schizophrenia, Catatonic Type (F20.2)
  - Schizophrenia, Disorganized Type (F20.1)
  - Schizophrenia, Paranoid Type (F20)
  - Schizophrenia, Residual Type (F20.5)
  - Schizophrenia, Undifferentiated Type (F20.5)
- Schizophreniform (F20.81)
- Shared Psychotic Disorder (F24)

Sexual dysfunctions
- Dyspareunia (F52.6)
- Female Orgasmic Disorder (F52.31)
- Female Sexual Arousal Disorder (F52.31)
- Gender Identity Disorder (F52.22)
- Hypoactive Sexual Desire Disorder (F64.2)
- Male Erectile Disorder (F52.21)
- Male Orgasmic Disorder (F52.8)
- Premature Ejaculation (F52.4)
- Sexual Aversion Disorder (F52.1)
- Vaginismus (F52)

Somatoform disorders
- Body Dysmorphic Disorder (F45.22)
— Conversion Disorder (F44.9)
— Hypochondriasis Disorder (F45.21)
— Pain Disorder (F45.19)
— Somatization Disorder (F45.20)

— Substance disorders
— Substance Abuse (F19.18)
— Substance Dependence (F19.28)

— Personality disorders
— Antisocial Personality Disorder (F60.2)
— Borderline Personality Disorder (F60.3)
— Narcissistic Personality Disorder (F60.81)
— Dependent Personality Disorder (F60.7)
— Histrionic Personality Disorder (F60.4)
— Paranoid Personality Disorder (F60)

TREATMENT PLANNING

— Treatment planning is the next step after a diagnosis is evident.
— Selection of a therapeutic method depends on the mode, time, and setting of treatment.
— Patient involvement is necessary in formulating a treatment plan.
— Treatment plan goals
  — To clarify treatment focus
    — What the treatment is meant to accomplish and through what means
  — To set realistic treatment expectations and goals
    — Treatment goals should have criteria for achievement, be achievable, and collaboratively developed and prioritized.
    — Expectations should adequately clarify to patients what they can realistically expect from a treatment course.
    — Clarify patient and provider roles, setting ground rules for therapy and establishing realistic goals agreed on by the patient.
  — To establish a standard for measuring treatment progress
    — Include a plan for reevaluation or follow-up.
  — To facilitate communication among professionals
  — For the purposes of managed health care, treatment plans also serve to support treatment authorization, to document quality assurance efforts, and to facilitate communication with external reviewers.

MODES OF TREATMENT

— Pharmacotherapy
  — Antidepressants: used to treat depression, panic attacks, OCD, PTSD, social anxiety disorder, anxiety, premenstrual dysphoric disorder, nicotine withdrawal symptoms
  — Mood stabilizers: used to treat bipolar disorder, dementia (anticonvulsants), severe agitation, aggression, severe impulsive behavior, mania, and disinhibition
  — Neuroleptics: used to treat schizophrenia, mania, delusional disorder, symptoms of psychosis, Tourette’s disease, Asperger’s syndrome
Anticholinergics: used for anxiety and stress reactions. Also used to offset extrapyramidal symptoms (EPS) for patients experiencing these symptoms while on antipsychotics.

Anxiolytics: used to treat anxiety disorders

Sedative hypnotics: used to treat insomnia and sleep disorders

Electroconvulsive therapy
- Major depression with or without psychotic features
- Bipolar illness (used to treat both depressed and manic phases)
- Catatonic schizophrenia
- Schizophrenia with strong affective components or schizophrenia highly resistant to treatment

Behavior therapy and cognitive therapy
- Used to help patients eliminate target behaviors; refer to additional texts for more information

Group psychotherapy
- Used to treat the following disorders in a group setting:
  - Most personality disorders
  - Most anxiety disorders
  - Somatoform disorders
  - Substance-related disorders
  - Schizophrenia and related psychotic disorders
  - Stable bipolar disorders
  - PTSD
  - Eating disorders
  - Medical illness
  - Depressive disorders
  - Adjustment disorders

Family/marital therapy

The Diagnostic Evaluation

THE PROCESS OF DIAGNOSTIC EVALUATION

A complete diagnostic evaluation involves obtaining a complete psychiatric history, including the presence of specific symptoms, course, and duration, in addition to the mental status exam (MSE), physical examination, pertinent labs, and other additional information. Diagnosis-specific questions for DSM criteria during the diagnostic encounter are the key.

Diagnosis-Specific Questions

As the interviewer develops hypotheses for a diagnosis, diagnosis-specific questions are asked to elicit DSM-5 criteria for diagnosis as follows:

- How long have you felt depressed?—the DSM-5 diagnosis for a major depressive disorder (MDD) requires at least 2 weeks of symptoms.
- Do you still derive pleasure from doing your favorite activities?—the DSM-5 diagnosis for MDD must include the presence of lack of pleasure (anhedonia) or a depressed mood.
- Are you able to function during the day on little to no sleep?—a decreased need for sleep is one of the possible criteria for a diagnosis of bipolar disorder.
Do you have flashbacks or nightmares of the traumatic event?—reexperiencing a trauma (via nightmares, flashbacks, obsessive thoughts) is part of the DSM-5 criteria of diagnosis for PTSD.

The interview may refer to additional diagnosis-specific screening questionnaires such as the following:
- Mini-Cog—instrument to assess dementia
- Mini-Mental State Examination—screening tool for cognitive function and impairment
- Clock drawing test—screening tool to assess executive function
- Beck Depression Inventory
- Hamilton Depression Scale
- Prime clinician instruments based on DSM criteria (intended for and sufficiently diagnostic in primary care settings)

**THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS**

**Diagnostic Criteria**
- Standard classification of mental health disorders used by mental health professionals in the United States.
- Designed for use across settings, such as inpatient, outpatient, partial hospital, clinic, private practice, and primary care; with community populations; and by psychiatrists, psychologists, nurses, occupational and rehabilitation therapists, counselors, social workers, medical students, and other health and mental health professionals.
- Necessary tool for collecting and communicating accurate public health data.
- Three major components: the diagnostic classification, the diagnostic criteria sets, and the descriptive text.
- For each disorder in the DSM, a set of diagnostic criteria indicates inclusion criteria (symptoms and length of presence) and exclusion criteria to qualify for a particular diagnosis.

**Psychological Testing in Psychiatry**

**WHAT IS PSYCHOLOGICAL TESTING?**

Psychological testing offers objective data about mental functioning. It involves administration, scoring, and interpretation of specific tasks in a controlled fashion. Tests must be
- Normed on a representative population
- Administered in a controlled environment
- Administered in a standard fashion
- Reliable and valid
- Culturally fair
- Scored according to standardized procedures
- Interpreted according to acceptable professional practices by a trained professional

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WHAT INFORMATION DOES PSYCHOLOGICAL TESTING PROVIDE, AND FOR WHOM IS IT APPROPRIATE?

Psychological testing has the ability to provide useful diagnostic information regarding level of intellectual functioning, identify and describe the nature of a mental health disorder, and indicate underlying motivation, personality attributes, and other variables.

- The patient must be able to participate in the assessment. Grossly confused or psychotic patients are not good candidates for psychological testing.
- Psychological testing is useful in treatment planning and outcome evaluation.
- Psychological testing is useful when objective data are required to establish a suspected diagnosis (sanity boards, interdiction).

TYPES OF PSYCHOLOGICAL TESTS

Many types of psychological tests are available to qualified users, which include the following:

- Measures of intellectual functioning
- Personality questionnaires
- Projective techniques
- Neuropsychological tests
- Measures of cognitive impairment

Associated tests include the following:

- Psychodiagnostic screening tests
- Educational diagnostic tests
- Aptitude tests
- Interest inventories

HOW TO DETERMINE THE APPROPRIATE TYPES OF PATIENTS FOR PSYCHOLOGICAL TESTING

- Almost anyone who possesses a reasonable reality orientation and is nonpsychotic is an appropriate candidate for psychological testing.
- Individuals with better mental statuses are capable of participating in more complex psychological testing procedures.
- Not all patients are capable of participating in all psychological tests. Physical handicaps, language barriers, and illiteracy may limit the available testing procedures.
- The willingness of the patient has an influence on the procedure. Angry or deceptive individuals may distort the outcome data. There are specific psychological tests to detect malingering and deception.
- Very specific referral questions allow for the selection of instruments (measures) to specifically address the reason for referral for testing.

HOW LONG SHOULD PSYCHOLOGICAL TESTING TAKE?

- The time to complete psychological testing depends on the referral questions and the number of testing procedures performed. The time may be as short as 2 hours or as long as 8 hours.
Testing can be expedited by prearranging appointments, providing relevant records and history, clear referral questions, and, when necessary, preapproval by third-party payers. Testing may be delayed when a third-party payer has questions as to the necessity of testing procedures, schedules are full, referral questions are vague, funding is unavailable, or the client is inappropriate for assessment.

WHO PERFORMS PSYCHOLOGICAL TESTS?

- A licensed psychologist or a technician under the supervision of a licensed clinical psychologist conducts psychological testing.
- Not all psychologists provide psychological testing and referrals are frequently made to specialists, especially in the case of neuropsychological assessment.
- Some states allow psychological testing to be conducted by nonpsychologists for specific purposes or in limited environments.

IMPORTANT ISSUES IN PSYCHOLOGICAL TESTING

- Reliability
- Validity
- Cultural bias
- Confidentiality
- Qualified examiners and assistants
- Explaining test results to referral sources

PSYCHOLOGICAL TESTS AND PROCEDURES OF IMPORTANCE IN PSYCHIATRY

The WAIS-IV

- The gold standard in the assessment of intellectual functioning
- Cross-culturally normed and can be used with any U.S. population above the age of 16 years
- Requires 60 to 90 minutes to administer
- Provides several IQ and index scores for different realms of intellectual ability

The MMPI-2

- The most widely investigated and empirically validated personality questionnaire available
- The self-report format consists of 556 true-and-false questions requiring 1 to 2 hours for completion.
- Has built-in validity scales to detect malingering and deception
- Consists of 10 basic clinical scales and supplemental scales to assess personality
- Has a number of presentation formats: paper, short form, and computer administration
- Optic scan options are available, which can then generate a written report for rapid review
The Rorschach
- The classic inkblot projective technique
- The patients are instructed to provide a description of what they see in an ambiguous picture
- The responses have been correlated with personality variables and psychopathology
- Requires specialized training and supervised practice to administer and interpret
- Computer programs are available to assist with scoring and interpretation

Self-Report Instruments
- Typically, self-report inventories are pencil-and-paper tests, wherein the patient endorses items either with a true/false or Likert-scale format.
- These reports can also be done in an interview format.
- They come in “short” and “long” versions, which take time to complete.
- These have been empirically validated with various clinical populations and demographic groups.

Common Measures
- The Beck Depression Inventory
- The Beck Anxiety Inventory
- The Hamilton Depression Scales
- The Hamilton Anxiety Scale

NEUROPSYCHOLOGICAL TEST BATTERIES
- A group of tests that describe brain–behavior relationships.
- Some tests are preselected and referred to as structured batteries while others are selected by the neuropsychologist as per the referral question and are known as flexible batteries.
- Individual tests assess psychological functions in different regions of the brain.
- The test results can be assembled to draw conclusions about damaged and persevered cognitive realms and abilities.
- Tests are useful in assessing the loss secondary to neurological insult and making predictions about recovery.
- Neuropsychological testing requires up to 8 hours of testing time.
- Specialized training is required to administer, score, and interpret measures used in neuropsychological assessment.

QUESTIONS FOR REFERRAL SOURCES TO ASK IN MAKING A REFERRAL
- Will psychological testing answer the questions I have about my patient?
- How soon will the psychologist see my patient?
- How long will the testing take?
- Is the procedure covered by my patient’s insurance?
- Does your office have a payment plan?
- How long will it take to get the results?
Will the psychologist go over the results with my patient and me?
If my patient has difficulty in understanding the results, can he or she come and see
the psychologist for further review?
Will the results include recommendations that I can implement?
How will my patient’s confidentiality and privacy be protected.

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