

**Human Behavior Course
2004**

**DIAGNOSTIC ASSESSMENT &
BIOPSYCHOSOCIAL FORMULATION**

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HUMAN BEHAVIOR COURSE 2004

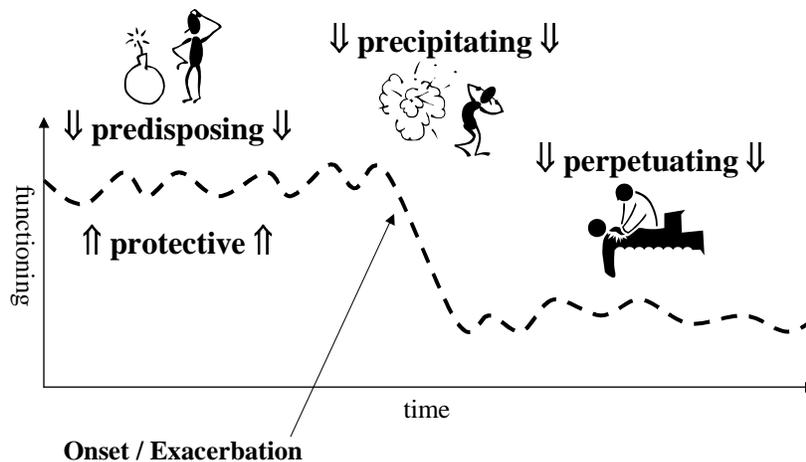
EVALUATION, DIAGNOSIS & FORMULATION - READING

This reading is your first exposure to the notion of patient formulation and psychiatric diagnosis. Be sure to read this before the upcoming small group discussion one if you don't read it before this lecture. Small group discussion one will give you a chance to practice these concepts. This reading and the accompanying lecture will introduce you to...

- I. The patient formulation
- II. The five diagnostic axes used in DSM-IV
- III. Two patient vignettes and some accompanying discussion questions

A good formulation is practical and useful and sometimes even smacks of a "work of art". A bad formulation, however, has the potential to leave you suspicious that the formulating clinician is a "fuzzy thinker" who is "winging it". In the section that follows, I will try to lay a simple and sensible framework for patient formulations.

The Four P's



I. The Elements of Formulation

"The Four P's" (**p**redisposing/**p**rotective, **p**recipitating, and **p**erpetuating factors) are the basic building blocks of the formulation. To insure your formulation is comprehensive, we recommend that you break each "P" into biological, psychological, and social considerations (figure 1). Breaking them down this far is a somewhat artificial and may cause you to "get lost in the biopsychosocial trees". If that happens, then take a step back so you can once again appreciate the "4-P forest"!

A. Predisposing and Protective factors (biological, psychological, and social)

Predisposing factors are the historical and constitutional vulnerabilities that were characteristic of the patient prior to the latest clinically relevant event or illness. Protective factors are essentially "predisposing factors in reverse". Protective factors are the characteristic strengths that can counteract predisposing vulnerabilities.

Predisposing and protective factors precede the onset of the symptoms, signs, and disability. Predisposing factors are aspects of individuals that render them more vulnerable to distress,

physiological arousal, and bothersome signs and symptoms. Predisposing and protective factors are often difficult or impossible to modify at the time of clinical presentation (for example, childhood physical or sexual abuse in an adult or a genetic predisposition to anxiety, depression, or disease). However, there may be approaches to mitigating the influence of predisposing factors or bolstering the impact of protective factors on subsequent risk of symptom onset, symptom persistence, impaired coping, psychosocial distress, and loss of functioning.

Biological predisposition/protection – Elements of biological predisposition/protection include an individual's genetic make-up (note that this is not synonymous with the family history, which is actually a combination of "nature" and "nurture"), past biomedical exposures (e.g., heavy metals, drugs of abuse, prescription and over the counter medications), and past medical and surgical histories.

Psychological predisposition/protection – These are factors that shape an individual's "perspective" such as relevant beliefs and expectations (e.g., "my friendships never last", "men only want me for sex", "people will 'do unto me' unless I 'do unto them' first") as well as predominant defense mechanisms (e.g. denial, repression, displacement, humor, altruism, splitting).

Social predisposition/protection – This is the sum of the patient's lifetime history of interpersonal, organizational, family, group, or societal functioning. For example, what sort of role models was the patient exposed to? How big was the family of origin? How well did the family "work" and what role did the patient tend to play in the family? Is the patient a follower or a leader? Does the patient function well in groups or is he a loner? Do others tend to respect or condescend to the patient? Does he tend to form stable or unstable relationships?

B. Precipitating factors (biological, psychological, and social)

A precipitating factor is essentially a "straw that breaks the camel's back." Precipitating factors or events send sufficiently vulnerable individuals into an episode of distress, illness, symptoms, or disability. Precipitating factors may also acutely exacerbate distress, illness/symptom severity, or disability among individuals who are already chronically ill (physically or mentally) but have existed in a 'compensated' status.

Biological precipitants – These are physiological perturbations such as an acute medical problem (e.g., exacerbation of hyperthyroidism), an extreme change of environment (e.g., sudden hot or cold temperatures), initiation of some new medication(s), or an illicit drug binge. For example, a man with congestive heart failure may have an acute panic attack triggered when he forgets to take his diuretic, develops mild pulmonary edema, and becomes noticeably short of breath. In this case, the pulmonary edema precipitates an illness episode. His preexisting congestive heart failure is considered a predisposing biological factor.

Psychological precipitants – These are psychological perturbations ranging from a catastrophic trauma (e.g., sexual assault) that would tax even the most resilient person to a mild stressor that most of us would handle with ease. Someone who is adequately predisposed can react to a seemingly mild psychological precipitant in an exaggerated way because the particular stressor holds internal meaning or exposes a problematic belief or defense mechanism. For example, a young man, whose father left his home without saying goodbye when the young man was 13 (this would be the predisposition – probably partly psychological and partly social) becomes unexplainably sad shortly after he begins a new job working for a man he believes to bear a resemblance to his father. The psychological precipitant in this case is the young man's belief that his new boss resembles his father, a belief that the young man may or may not be consciously aware of. One might hypothesize that the young man is depressed because of the unsupported expectation (a psychological predisposition based on a childhood experience erroneously generalized to his current situation) that this boss will not care about him and eventually 'junk' him, as he perceives that his father once did.

Social precipitants – Social precipitants are perturbations of interpersonal, organizational, family, group, or societal significance. This may include events such as divorce or other broken relationships; change of command in a military unit; socially taboo relationships such as fraternization, incest, or harassment; unsanctioned group behavior such as fighting, criticizing a colleague during medical rounds, military misconduct, or criminal behavior; or catastrophic societal events such as war or terrorism. The example of the young man who believes his new boss looks like his father also has elements of a social precipitant: he has undergone a change in his work status and is probably responding to someone in an occupational position of authority over him as he might have responded

to his father in childhood (note that his father is in an analogous position of authority over his family as his new boss is over his new work “family”).

C. Perpetuating factors (biological, psychological, and social)

Perpetuating factors are those that sustain or maintain illness, behavior, symptoms, or disability, thereby extending duration and impact. Perpetuating factors are especially important in understanding the course of chronic illness (or the reasons why an acute illness develops into a chronic one).

Perpetuating factors are often independent of the circumstances originally precipitating an illness. For example, a person may develop acute stress disorder because of a wartime traumatic experience, but the illness is sustained and becomes chronic post-traumatic stress disorder partly because his war experiences becomes an important way of bonding with other veterans and a mark of virtue and standing within the larger community of war veterans.

Biological perpetrators – These are physiological factors that extend the life of an illness. For example, an alcoholic may remain chronically depressed because of a direct effect of the drug on his central nervous system. Similarly, a man with intermittent atrial fibrillation who suffers with agoraphobia due to a panic attack that occurred many months ago finds his disabling fear of a future panic attack is extended by occasional bouts of tachycardia leading to acute fear when he goes into atrial fibrillation. Another man with chronic obstructive lung disease has recurrent panic attacks that get triggered when he feels short of breath. In this last example, an exacerbation of the lung disease is a biological precipitant while the chronic nature of the lung disease is what perpetuates the panic disorder with agoraphobia. We don’t have enough information, but it is possible that the man’s lung disease was also a predisposing factor for the original onset of his illness (e.g., he may have misinterpreted his first episode of panic as an exacerbation of chronic lung disease, intensifying the severity of the panic attack itself).

Psychological perpetrators – These are expectations, beliefs, or defense mechanisms that extend the duration of illness. For example, if a housewife believes that her husband will leave her if she shows competence, then disability may become extended to “achieve” and sustain an acceptable level of “incompetence.” If a mother thinks a panic attack is likely when she is driving with her children, then she may stay at home, even though her last panic attack was several years ago.

Social perpetrators – Social perpetrators are interpersonal, organizational, family, group, or societal forces that sustain illness. For example, the housewife just above may in fact accurately perceive that her husband will reject her if she is competent (e.g., becomes the family “breadwinner”) and her depression is sustained out of a reluctance to endanger the relationship by blossoming in family status. The example previously cited of the war veteran whose illness persists to insure his stature in the community of veterans is yet another description of a social perpetrator.

D. Treatment Factors (biological, psychological, and social)

Treatments are a special type of “perpetuating” factor. Treatments, like other perpetuating factors, modify the duration or severity of symptoms, illness, and disability after they have been precipitated. However, instead of prolonging illness, treatments are obviously intended to reduce illness duration. Sometimes, however, treatments may prolong symptoms right along with other perpetuating factors. For example, someone experiencing sexual feelings toward their therapist might not “get better” because the patient perceives that getting better would lead to the end of therapy sessions. Similarly, a patient receiving opioid analgesics for chronic pain may fail to improve because the medication is positively reinforcing the pain and contributing to related disability. As in the previous example, this patient continues to manifest symptoms to avoid the end of treatment.

Biological treatments – Biological treatments used in psychiatry include the pharmacotherapies such as antidepressants and antipsychotics. Other biological therapies include chronotherapy (adjusting diurnal cycle, often through the use of high intensity lighting or “phase shifting” the beginning and end of each day over a period of time) and electroconvulsive therapy (ECT). The goal of the biological therapies is to alter thinking, emotions, and behavior in some predictable and positive way by intervening at the physiological level.

Psychological treatments – Psychological treatments involve short and long term psychotherapies. These include the behavioral therapies, cognitive therapy, psychodynamic therapy, supportive therapy, and so on. The goal of the psychological therapies is to alter thinking, emotions,

and behavior in some predictable and positive way through supervised learning and/or careful examination of existing patterns of thinking, emotions, and behavior.

Social treatments – The goal of social therapies is to alter thinking, emotions, and behavior in some predictable and positive way through intervention at the interpersonal or group level. Examples of social therapies are group, couples, and marital therapies. Other social interventions involve efforts at the family, occupational, or residential level. Examples include welfare benefits, disability compensation, arrangements for shelter, various community services, or military or work-related social programs.

It should be apparent from these examples that our conceptual notion of a “biopsychosocial” formulation suffers from inadequacies. What constitutes the “bio”, the “psycho”, and “social” elements overlaps extensively and may depend more on your theoretical perspective than what is “true”. It is probably best understood that all of these processes are inter-related and overlapping and no one factor (e.g., psychological) ever occurs in the absence of other factors (e.g., biological and social).

II. Putting The Patient Formulation Together

	Biological	Psychological	Social
Predisposing			
Protecting			
Precipitating			
Perpetuating			
Treatments			

Now that you have been introduced to the **4 P’s**, the remaining step is to put the components together in a formulation. The primary objective of the formulation is to capture “what is going on” with your patient in an accurate, efficient, and global manner. Think of the formulation as your way of conveying the patient to a listener in a few sentences. What follows is one *formulation formula*.

Formula: *“The patient is an [umpty-dump] year old male/female with a history of [list important predisposing factor(s)]. He/she first sought care [days/weeks/months] ago for [symptoms/disability] seemingly brought about by [precipitating factors]. Since seeking care, Mr. X has been treated effectively with [treatment factors].” AND/OR “Some issues complicating treatment (or sustaining symptoms) are [perpetuating factors]”*

Example One: “Mr. X is a 31 year old married Gulf War veteran retired from the military for chronic pain, depression, and fatigue diagnosed as fibromyalgia, whose father is a disabled Vietnam War veteran with alcohol problems [predisposing factors]. Mr. X presents now in a wheelchair with an exacerbation of fatigue and total body pain the day after a major media report [precipitating factor] about a “possible cause” of Gulf War Syndrome. Mr. X is a member of several veterans’ advocacy groups and recently testified in a wheelchair to Congress regarding the severity of his illness and the incompetence of military doctors attempting to treat it [perpetuating factors].

Example Two: “Ms. Y is a 34 year old single woman who was repeatedly abused sexually by her step father from ages 7 to 14 and has had a pattern of impulsive and self-destructive relationships and recurrent

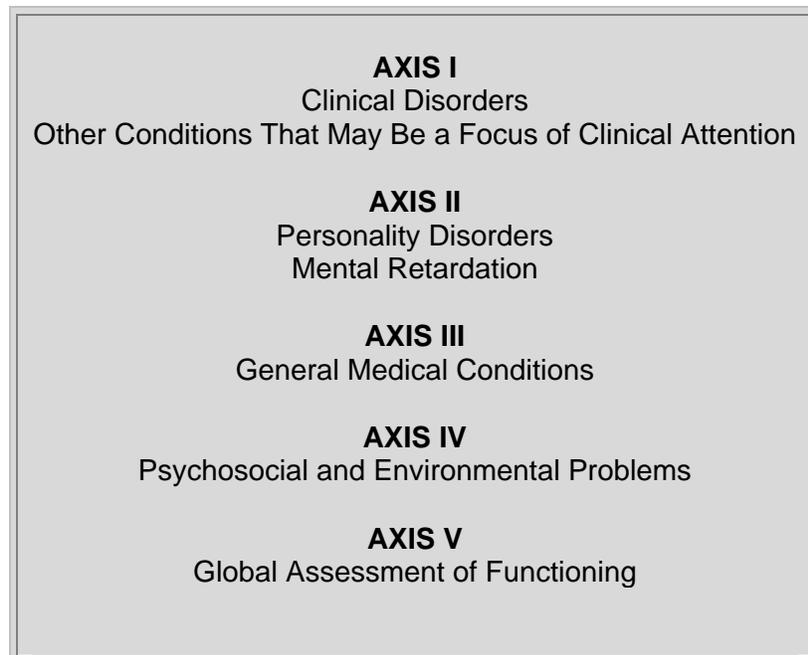
major depressive disorder as an adult [all predisposing factors]. She presented to the emergency room three week ago for symptoms of depression with suicidal ideation precipitated by recent separation for her boyfriend [precipitating factor]. Though she lives alone and has few social supports but has shown an early favorable response to the antidepressant sertraline 150 mg daily and weekly supportive therapy sessions [perpetuating factors and treatments].”

Example Three: “Ms. Z is a 45 year old woman with no prior psychiatric history and a brother with a history of depression [predisposing factor] who presents during a scheduled intake complaining of new depressive symptoms over the past week after her husband of 23 years left her for another woman [precipitating factors]. [There are no perpetuating factors in this example because the symptoms are new]

This series of quick formulations illustrates the general idea behind the patient formulation. You can (and should) elaborate on these simplified formulations as time allows and context of the presentation necessitates.

III. Clinical Diagnosis and the Multiaxial Assessment

The next sections deal with clinical diagnosis. The multiaxial diagnostic system used in psychiatry involves an assessment on several axes, each of which refers to a different domain of information that may help clinicians plan treatment and predict outcome. There are five separate axes included in the DSM-IV multiaxial classification. These are listed in the box below.



A primary objective behind the use of this multiaxial diagnostic system is to facilitate comprehensive and systematic evaluation with attention to the various mental disorders and general medical conditions, psychosocial and environmental problems, and level of functioning that might be overlooked if the focus was on arriving at a single all encompassing diagnosis. The multiaxial diagnostic system used in psychiatry provides a convenient format for organizing and communicating clinical information, for capturing the complexity of clinical situations, and for describing the individual patient differences among people with the same primary diagnosis. In addition, the multiaxial system helps facilitate application of the biopsychosocial model in clinical, educational, and research settings.

The next sections describe each axis in greater detail.

Axis I: Clinical Disorders Other Conditions That May Be a Focus of Clinical Attention

Axis I is for reporting the “clinical disorders.” These are essentially all the disorders or conditions listed in DSM-IV except for the Personality Disorders and Mental Retardation (these diagnoses are reported on Axis II). The major groups of disorders reported on Axis I are listed below. Don’t worry much about what these disorders represent just yet. You will learn more about most categories in the weeks to come (I’ve marked the categories below that we will cover during the course with an asterisk). Also reported on Axis I are Other Conditions That May Be a Focus of Clinical Attention. These are not “disorders” but rather situations or life circumstances that sometimes cause people to seek psychiatric care. When an individual has more than one Axis I disorder (something that frequently happens – a situation quite different from nearly all other medical disciplines), all of these should be listed. By convention, you should list the primary diagnosis first (usually the most disabling or serious disorder, the disorder you think is leading to all other disorders, or the disorder accounting for the patient’s chief complaint).

If no Axis I disorder is present, the convention is to write, “deferred” under Axis I.

AXIS I Clinical Disorders Other Conditions That May Be a Focus of Clinical Attention

Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence (excluding Mental Retardation)
Delirium, Dementia, and Amnesic and Other Cognitive Disorders
Mental Disorders Due to a General Medical Condition
Substance-Related Disorders
Schizophrenia and Other Psychotic Disorders
Mood Disorders
Anxiety Disorders
Somatoform Disorders
Factitious Disorders
Dissociative Disorders
Sexual and Gender Identity Disorders
Eating Disorders
Sleep Disorders
Impulse-Control Disorders Not Elsewhere Classified
Adjustment Disorders
Other Conditions That May Be a Focus of Clinical Attention

Axis II: Personality Disorders & Mental Retardation

Axis II is for reporting Personality Disorders and Mental Retardation. Axis II may also be used to indicate prominent maladaptive personality features and/or defense mechanisms that do not meet the threshold for a Personality Disorder. The listing of Personality Disorders and Mental Retardation on a separate axis ensures that consideration will be given to the possible presence of Personality Disorders and Mental Retardation that might otherwise be overlooked. As on Axis I, if an individual has more than one diagnosis on Axis II, then all diagnoses are listed. The disorders reported on Axis II are listed in the box.

AXIS II
Personality Disorders
Mental Retardation

Paranoid Personality Disorder
Schizoid Personality Disorder
Schizotypal Personality Disorder
Antisocial Personality Disorder
Borderline Personality Disorder
Histrionic Personality Disorder
Narcissistic Personality Disorder
Avoidant Personality Disorder
Dependent Personality Disorder
Obsessive-Compulsive Personality Disorder
Personality Disorder Not Otherwise
Specified
Mental Retardation

Axis III: General Medical Conditions

Axis III is used to report medical conditions that are potentially relevant to the understanding and/or management of a person's mental disorder. These conditions are those that are classified outside the "Mental Disorders" section of International Classification of Diseases (ICD-9 or ICD-10). A listing of the broad categories considered under Axis III may be found in the "Axis III" box.

General medical conditions can be related to mental disorders in a variety of ways. In some cases it is clear that the general medical condition is directly etiological to the development or worsening of mental symptoms and that the mechanism for this effect is physiological. When a mental disorder is judged to be a direct physiological consequence of the general medical condition, a Mental Disorder Due to a General Medical Condition should be diagnosed on Axis I and the exacerbating medical condition gets recorded on both Axis I and Axis III. For example, when hypothyroidism is a direct cause of depressive symptoms, the designation on Axis I is 293.83 Mood Disorder Due to Hypothyroidism, With Depressive Features, and the hypothyroidism is listed again and coded on Axis III.

In those instances in which the relationship between the general medical condition and the mental symptoms is insufficiently clear to warrant an Axis I diagnosis of Mental Disorder Due to a General Medical Condition (that is, it is not clear whether the medical condition is physiologically linked to mental symptoms), the appropriate mental disorder (e.g., Major Depressive Disorder) gets listed on Axis I and the medical condition only gets coded on Axis III.

Other times, a medical condition is recorded on Axis III because of its importance for understanding or treatment of the individual with a mental disorder. An Axis I disorder may be a psychological reaction to an Axis III general medical condition (e.g., the development of Adjustment Disorder With Depressed Mood as a reaction to the diagnosis of carcinoma of the breast). Some medical conditions may not be directly related to a mental disorder but nonetheless have important prognostic or treatment implications (e.g., when the diagnosis on Axis I is Major Depressive Disorder and on Axis III is arrhythmia, the choice of pharmacotherapy is influenced by the general medical condition; or when a person with diabetes mellitus is admitted to the hospital for an exacerbation of Schizophrenia and insulin management must be monitored).

If an individual has more than one clinically relevant Axis III diagnosis, all of them should be listed. If no Axis III disorder is present, then write "None" under Axis III. If an Axis III is suspected but unconfirmed, write "deferred" under Axis III while further diagnostic information is gathered.

AXIS III
General Medical Conditions (with ICD-9-CM codes)

Infectious and Parasitic Diseases (001-139)
Neoplasms (140-239)
Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders (240-279)
Diseases of the Blood and Blood-Forming Organs (280-289)
Diseases of the Nervous System and Sense Organs (320-389)
Diseases of the Circulatory System (390-459)
Diseases of the Respiratory System (460-519)
Diseases of the Digestive System (520-579)
Diseases of the Genitourinary System (580-629)
Complications of Pregnancy, Childbirth, and the Puerperium (630-676)
Diseases of the Skin and Subcutaneous Tissue (680-709)
Diseases of the Musculoskeletal System and Connective Tissue (710-739)
Congenital Anomalies (740-759)
Certain Conditions Originating in the Perinatal Period (760-779)
Symptoms, Signs, and Ill-Defined Conditions (780-799)
Injury and Poisoning (800-999)

Axis IV: Psychosocial and Environmental Problems

Axis IV is where assessments of psychosocial and environmental problems that may affect the diagnosis, treatment, and prognosis of mental disorders (Axes I and II) are recorded. A psychosocial or environmental problem may be a negative life event, an environmental difficulty or deficiency, a familial or other interpersonal stressor, an inadequate social support system or personal resources, or another problem relating to the context in which a person's difficulties have developed. So-called positive stressors, such as job promotion, should only get recorded on Axis IV if they constitute or lead to a problem, as when a person is having difficulty adapting to the new situation. In addition to playing a role in the initiation or exacerbation of a mental disorder, psychosocial problems may also develop as a consequence of a person's mental disorder or may constitute problems that merit consideration in the overall management plan.

When a person has multiple psychosocial or environmental problems, the clinician can note as many as are relevant. In general, the clinician only notes those problems that have been present during the year preceding the current evaluation. Sometimes, however, psychosocial and environmental problems occurring prior to the previous year are recorded under Axis IV if they clearly contribute to a mental disorder or have become a focus of treatment (for example, previous combat experiences leading to Post-Traumatic Stress Disorder).

Almost always, psychosocial and environmental problems are indicated on Axis IV. However, if a psychosocial or environmental problem is the primary focus of clinical attention, it is then appropriate to record it on Axis I too, using one of the conditions found under "Other Conditions That May Be a Focus of Clinical Attention" (so-called "v-codes").

AXIS IV
Psychosocial and Environmental Problems

Problems with primary support group
Problems related to the social environment
 Educational problems
 Occupational problems
 Housing problems
 Economic problems
Problems with access to health care services
Problems related to interaction with the legal
 system/crime
Other psychosocial and environmental problems

For convenience, problems recorded under Axis IV get grouped according to the following categories:

- Problems with primary support group:
 For example, death of a family member; health problems in family; disruption of family by separation, divorce, or estrangement; removal from the home; remarriage of parent; sexual or physical abuse; parental overprotection; neglect of child; inadequate discipline; discord with siblings; birth of a sibling.
- Problems related to the social environment:
 For example, death or loss of friend; inadequate social support; living alone; difficulty with acculturation; discrimination; adjustment to life-cycle transition (such as retirement).
- Educational problems:
 For example, illiteracy; academic problems; discord with teachers or classmates; inadequate school environment.
- Occupational problems:
 For example, unemployment; threat of job loss; stressful work schedule; difficult work conditions; job dissatisfaction; job change; discord with boss or co-workers.
- Housing problems:
 For example, homelessness; inadequate housing; unsafe neighborhood; discord with neighbors or landlord.
- Economic problems:
 For example, extreme poverty; inadequate finances; insufficient welfare support.
- Problems with access to health care services:
 For example, inadequate health care; transportation to health care facilities unavailable; inadequate health insurance.
- Problems related to interaction with the legal system/crime:
 For example, arrest; incarceration; litigation; victim of crime.
- Other psychosocial and environmental problems:
 For example, exposure to disasters, war, other hostilities; discord with nonfamily caregivers such as counselor, social worker, or physician; unavailability of social service agencies.

Axis V: Global Assessment of Functioning

Axis V is for assessing a person's overall level of functioning. This information is useful for planning treatment, measuring the impact of treatment, and predicting outcome. Reporting of overall functioning on Axis V is often done using a measure called the Global Assessment of Functioning (GAF) Scale (see box on the page following this section). The GAF Scale may be particularly useful in tracking the clinical progress of individuals in global terms, using a single measure. The GAF Scale is rated with respect only to psychological,

social, and occupational functioning. The instructions specify, "Do not include impairment in functioning due to physical (or environmental) limitations."

In most instances, ratings on the GAF Scale should be for the current period (i.e., the level of functioning at the time of the evaluation) because ratings of current functioning will generally reflect the need for treatment or care. For patients who are followed over time (e.g., hospitalized patients or those participating in a time limited therapy or treatment program), it is useful to note the GAF Scale rating at different time points (e.g., admission – discharge or time one – time two). When performing a single cross-sectional assessment, the GAF Scale may be rated for another time period besides the present one (e.g., the highest sustained level of functioning during the past year). The GAF Scale is usually reported on Axis V as: "GAF =", followed by the GAF rating from 1 to 100, followed by the time period reflected in the rating in parentheses, for example, "(current)," "(highest level in past year)," or "(at discharge)."

GLOBAL ASSESSMENT OF FUNCTIONING (GAF) SCALE

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

CODE

91-100

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.

81-90

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).

71-80

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).

61-70

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 the household), but generally functioning pretty well, has some meaningful interpersonal relationships.

51-60

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).

41-50

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).

31-40

Some impairment in reality testing or communication (e.g., speech is at times 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).

21-30

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).

11-20

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).

1-10

Persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.

0

Inadequate information.

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EVALUATION, DIAGNOSIS & FORMULATION - SLIDES

LEARNING OBJECTIVES & ISSUES FOR THOUGHT.

1. What is DSM? What important change did DSM-III implement from previous versions?
2. What is “multiaxial assessment”? What does it “do”?
3. Name the five basic axes of DSM-IV psychiatric diagnostic assessment and define each of them.
4. Compare and contrast DSM-IV axis I, II, and III.
5. List the basic categories of psychiatric diagnoses and what axis is should fall under.
6. What is “operationalism”?
7. What is “phenomenology”?
8. What are reliability and validity and how are they relevant to operationalism?
9. Contrast form and function? How does it apply to psychiatric assessment?
10. Know the elements of the psychiatric history.
11. What is malingering and what lesson should it teach us about the medical history?
12. Know the meaning of the bolded terms in Cohen chapter 2
13. Know the broad types of psychological testing and interviewing.
14. Contrast the “disease”, dimension, behavior, and life story perspectives. Which ones do you find most clinically relevant? Why?

Diagnostic Classification & Formulation in Psychiatry

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Terms & Concepts

- ★ operationalism
- ★ phenomenology
- ★ reliability
- ★ validity
- ★ operational criteria
- ★ DSM
- ★ atheoretical
- ★ form versus function
- ★ antipsychiatry
- ★ biopsychosocial model
- ★ reductionism
- ★ descriptive observations
- ★ psychological interpretations
- ★ diseases versus choices
- ★ weakness
- ★ akinesia
- ★ akathisia
- ★ hypertonicity
- ★ spasticity
- ★ rigidity
- ★ paratonia (Gegenhalten)
- ★ cogwheel rigidity



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Terms & Concepts 2

- ★ dystonia
- ★ tremor
- ★ chorea
- ★ dyskinesia
- ★ tardive dyskinesia
- ★ myoclonus
- ★ asterixis
- ★ stereotypies
- ★ catatonia
- ★ catalepsy
- ★ waxy flexibility
- ★ bizarre posturing
- ★ stupor
- ★ mutism
- ★ negativism
- ★ impulsiveness
- ★ grimacing
- ★ mannerisms
- ★ echopraxia
- ★ echolalia
- ★ verbigeration
- ★ formal thought disorder
- ★ speech latency
- ★ pressured speech



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Terms & Concepts 3

- ★ flight of ideas
- ★ retardation of speech
- ★ circumstantiality
- ★ loosening of associations
- ★ tangentiality
- ★ poverty of thought
- ★ neologisms
- ★ telegraphic speech
- ★ clang associations
- ★ rhyme associations
- ★ thought blocking
- ★ diurnal variation
- ★ anhedonia
- ★ vegetative
- ★ neurovegetative
- ★ early awakening
- ★ suicidal ideation
- ★ passive death wishes
- ★ active suicidal intent
- ★ violent ideation
- ★ homicidal ideation
- ★ labile
- ★ hypomania
- ★ mood
- ★ affect



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Terms & Concepts 4

- ★ emotional incontinence
- ★ hallucinations
 - elementary
 - complex
 - command
 - hypnagogic
 - hypnopompic
 - Pseudo-
- ★ illusions
- ★ delusions
- ★ overvalued ideas
- ★ obsessions
- ★ compulsions
- ★ cognition
- ★ agnosia
- ★ intelligence
- ★ abstract thinking
- ★ insight
- ★ judgment
- ★ tests
 - cognitive
 - achievement
 - neuropsychological
 - personality
 - symptom severity
 - semistructured interviews



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Overview

- ★ Background
- ★ History & basis of DSM-IV
- ★ The disorders
- ★ The formulation
 - multiaxial diagnosis & "perspectives"
 - biopsychosocial



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Phenomenology

- ★ The study of the mind indirectly through its public and observable expression
- ★ Allows the 'operationalization' of mental disorders
- ★ Direct observation of –
 - Behaviors including
 - Symptom reports
- ★ The basis of our current diagnostic system in psychiatry



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What is the *Primary Purpose* of Diagnostic Classification?

To improve the health of diseased groups or individuals



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Some Other Common Uses

- ★ Third-party payment for care
- ★ Indication of need or care justification
- ★ Forensic assessments (responsibility)
- ★ Administrative dispositions
- ★ Disability compensation



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American Psychiatric Association's Diagnostic & Statistical Manual of Mental Disorders

The standard (and categorical)
diagnostic nomenclature currently
used in US psychiatry.



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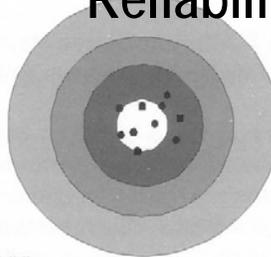
Categorical Diagnosis

A 'yes/no' approach to classification that postulates discrete diagnostic entities.

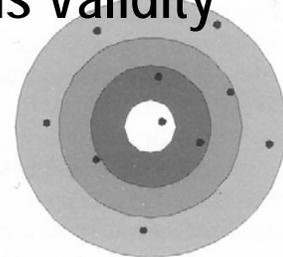


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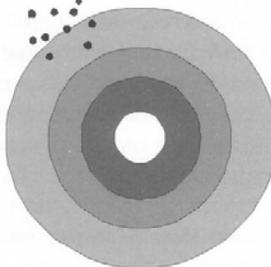
Reliability Versus Validity



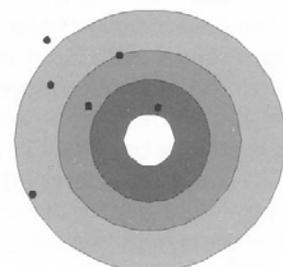
High Validity
High Reliability



High Validity
Low Reliability



Low Validity
High Reliability



Low Validity
Low Reliability

The History of DSM

- ★ 1952: DSM-I -- a response to ICD-6
- ★ 1968: DSM-II -- minor changes to DSM-I
- ★ 1980: DSM-III -- many important changes
 - explicit diagnostic criteria
 - atheoretical & phenomenological orientation
 - multi-axial assessment
- ★ 1987: DSM-III-R -- 'smoothed' some issues
- ★ 1994: DSM-IV -- refined process



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DSM-IV

What A Mental Disorder IS

"a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or disability or with a significantly increased risk of suffering, death, pain, disability, or an important loss of freedom."



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DSM-IV

What a mental disorder ISN'T

- ★ not an 'expectable and culturally sanctioned response' to an event
- ★ not 'deviant behavior (political, religious, or sexual)'
- ★ not 'conflicts primarily between an individual and society' per se



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DSM-IV Diagnostic Categories

- ★ Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence
- ★ Substance-Related Disorders
- ★ Schizophrenia
- ★ Mood Disorders
- ★ Anxiety Disorders
- ★ Somatoform Disorders
- ★ Dissociative Disorders
- ★ Sexual & Gender Identity Disorders
- ★ Sleep Disorders
- ★ Eating Disorders
- ★ Factitious Disorders
- ★ Adjustment Disorders
- ★ Impulse-Control Disorders
- ★ Personality Disorders
- ★ Other Conditions That May Be A Focus of Clinical Attention
- ★ Dementia, Delirium & Cognitive Disorders



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Clinical or Biopsychosocial Formulations



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“Mental Life” Form Versus Function

Form

1. Emphasizes brain
2. Goal is explanation
3. Person as object/organism
4. Person from “outside”
5. Seeks causality
6. Asks “what”

Function

1. Emphasizes mind
2. Goal is empathy & understanding
3. Person as subject/agent
4. Person from “inside”
5. Seeks meaning & connections
6. Asks “why”



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Multiple "Perspectives"

- ★ Disease – 'what the patient has'
- ★ Dimensional – 'where the patient is'
- ★ Behavioral perspective – 'what the patient does'
- ★ Life-story perspective – 'who the patient is'



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Five Classification Dimensions

- ★ Axis I - Clinical Syndromes
- ★ Axis II - Personality Disorders
Mental Retardation
- ★ Axis III - General Medical Conditions
- ★ Axis IV - Psychosocial & Environmental
Problems
- ★ Axis V - Global Assessment of Functioning



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DSM-IV Axis I

Clinical Disorders and Other Disorders that may be the Focus of Treatment:

- ★ principal diagnosis listed first
- ★ multiple diagnoses allowed
- ★ no diagnosis (V71.09)
- ★ axis I diagnosis deferred (799.9)



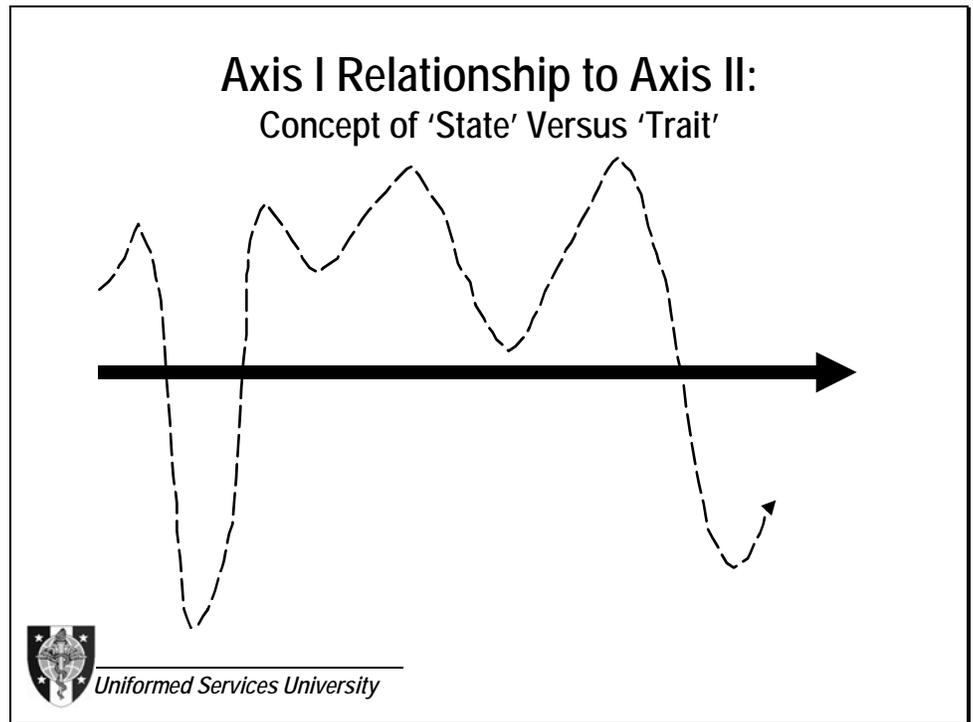
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DSM-IV Axis II Personality Disorders

- ★ paranoid
- ★ schizoid
- ★ schizotypal
- ★ antisocial
- ★ borderline
- ★ histrionic
- ★ narcissistic
- ★ avoidant
- ★ dependent
- ★ obsessive-compulsive
- ★ personality "NOS"



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- ### DSM-IV Axis III General Medical Conditions
- ★ infectious/parasitic
 - ★ neoplasm
 - ★ endocrine, nutritional, metabolic, & immunity
 - ★ hematological
 - ★ neurological
 - ★ circulatory
 - ★ respiratory
 - ★ digestive
 - ★ genitourinary
 - ★ pregnancy/childbirth
 - ★ skin
 - ★ musculoskeletal & connective
 - ★ congenital anomalies
 - ★ perinatal problems
 - ★ ill-defined conditions
 - ★ injury/poisoning
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DSM-IV Axis IV Psychosocial & Environmental Problems

primary support group problems
social environment problems
educational problems
occupational problems
housing problems
economic problems
problems with access to health care
problems related to legal system/crime



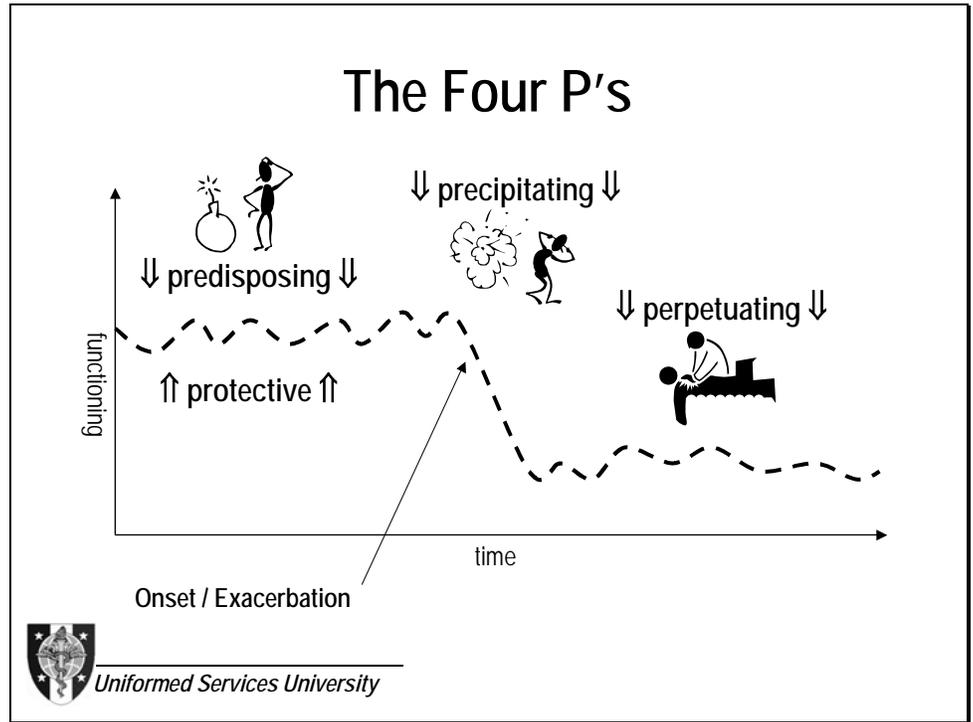
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DSM-IV Axis V Global Assessment of Functioning

- ★ Rates psychological, social, and occupational functioning
- ★ Excludes impairment from physical or environmental limitations
- ★ 'trait' measure of functioning (best in past year)
- ★ 'state' measure of functioning (current)
- ★ suggests that discharge rating be recorded in summaries



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	Biological	Psychological	Social
Predisposing			
Protecting			
Precipitating			
Perpetuating			
Treatments			

Questions?



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