

# 2

## *Biopsychosocial Assessment and Case Formulation*

Alan Stoudemire

The preceding chapter focused on the basics of the psychiatric history, mental status examination, physical and laboratory assessment, and DSM-IV as a descriptive psychiatric classification system. Based on the information gathered in this type of initial assessment, a preliminary diagnosis and treatment plan can then be made. A more in-depth psychological evaluation, however, is then required. Examples of patients in whom an in-depth psychosocial assessment is called for include the following:

1. Patients who appear to have complex or problematic family, marital, or interpersonal problems.
2. Patients who appear to have *repetitive* patterns of conflicts or difficulties in their interpersonal relationships.
3. Individuals who appear to have psychiatric disorders and symptoms that are apparently precipitated or exacerbated by social, occupational, family, or interpersonal factors.
4. Patients who have unexplained somatic symptoms that cannot be explained on the basis of physical or laboratory findings.
5. Children and adolescents with psychiatric symptoms.

By emphasizing the importance of psychosocial assessment, one should not necessarily assume that such factors are the direct *cause* of the patient's psychiatric disorder—this may or may not be the case. The relative contribution of psychosocial factors in precipitating the onset or exacerbation of psychiatric disorders and symptoms varies depending on the disorder being evaluated. Moreover, the relative contribution of psychosocial factors to the cause of many psychiatric disorders remains

highly controversial in the psychiatric literature. To take the position that psychosocial factors are important in the assessment of a patient who has a psychiatric disorder such as schizophrenia, however, is not the same as saying that schizophrenia is *caused* by psychosocial factors, because schizophrenia is now considered to derive primarily from predisposing genetic and biological factors. Nevertheless, few psychiatrists would argue against the position that psychosocial and environmental factors may be involved in relapses of schizophrenia or that schizophrenia has profound effects on the patient's social and interpersonal functioning. Likewise, vulnerability to panic disorder and the major mood disorders appears to be strongly determined by biological factors, yet certain patients may have their symptoms precipitated or exacerbated under certain types of emotionally stressful conditions. *Hence, even though certain disorders may have a primarily genetic and biological basis in respect to their underlying pathophysiology, the disorder's onset and relapse may be affected by social or environmental factors in the biologically predisposed individual.* Even in physical disorders, acute and chronic illness always poses a form of stress for the individual that may potentially affect every aspect of their family, social, and occupational life. For example, cancer and chronic renal disease may have devastating effects on the patient's emotional and social functioning (Green, 1994). Psychological reactions to physical illness are further discussed in Chapters 9 and 20.

## GOALS OF PSYCHOSOCIAL ASSESSMENT

The primary goals of a comprehensive psychosocial evaluation are to: (1) assess if psychological or social factors are important in contributing to the patient's vulnerability to psychiatric illness, (2) assess if psychosocial factors are significant in causing relapse or exacerbation of symptoms, and (3) identify areas in the psychological or social realm where treatment efforts might be focused. In addition, such an assessment also will identify areas in the patient's support system that may be a resource. In patients who suffer primarily from repetitive problems in their interpersonal relationships or who have dysfunction within the family system, the psychosocial assessment may be the only means of fully understanding their condition and planning an effective course of treatment.

## PSYCHODYNAMIC ASSESSMENT

A *psychodynamic* assessment is a more specialized form of psychological evaluation that is usually performed by a psychiatrist who endorses and is trained in this method of evaluation. An in-depth psychodynamic assessment may be needed as part of the psychosocial assessment in some situations and involves examining the key developmental life experiences that may have affected the patient's personality formation, the nature of the patient's past and current family relationships, the patient's psychological strengths and vulnerabilities, and the patient's characteristic defense mechanisms. A psychodynamic assessment also evaluates current interpersonal stresses that may be affecting the patient and therefore overlaps with the

general psychosocial evaluation. Individuals and important environmental and family events that have influenced the patient in either a positive or negative manner are identified, and the effect they currently have or have had on the patient is evaluated. Psychodynamic assessment is often critical not only in developing a comprehensive understanding of the patient's personality and current difficulties but also in determining whether or not psychotherapy is required, and, if so, what type of psychotherapy would be most appropriate.

Psychodynamic assessment is a form of evaluation somewhat more specialized than a general psychosocial assessment and is largely based on a psychoanalytic frame of reference. Psychodynamic assessment imparts major significance to developmental influences on the patient within the family system and potential unconscious factors that may be affecting the patient's behavior, motivations, and interpersonal relationships. Psychodynamic assessment thus focuses on the influence of early relationships on the patient's personality formation, the patient's ego defense mechanisms, and the effects that these early relationships have on their interpersonal relationships.

Some psychoanalytic and psychodynamic theorists have attempted to explain all psychiatric illness—including major disorders such as schizophrenia, major depression, and anxiety disorders—in their most doctrinaire form as deriving from intrapsychic and unconscious mental processes. Personality disorders and other disturbances in behavior also were explained primarily on a psychodynamic basis as deriving from abnormal or otherwise conflicted childhood developmental experiences and dysfunction within the family system.

Recent advances in biological psychiatry and psychopharmacology in some instances have almost completely usurped primarily psychoanalytic and psychodynamic viewpoints with respect to *etiological* explanations for the major mental disorders such as schizophrenia, major depression, and bipolar disorder. In addition, psychoanalytically oriented therapies for these disorders based on these types of purist etiological explanations have been under serious criticism. Although considerable polarization and strain exist within the field of psychiatry regarding the relative contribution of psychodynamic factors in the cause of the major psychiatric disorders, there has been a recent trend to attempt to integrate biological and psychological viewpoints regarding the etiology and treatment of psychiatric illness (Cooper, 1985; Kandel, 1979, 1983; Reiser, 1984; van der Kolk, 1994). In addition, it is recognized that the relative contribution of psychological and biological factors varies with the psychiatric disorder being studied and that even within a given disorder (such as major depression) considerable heterogeneity exists among patients who may carry the same primary diagnosis.

Further discussion of this area is beyond the scope of this text, and the philosophy of this text that, given our limited knowledge of the precise cause of most psychiatric disorders, a balanced approach should be taken in patient evaluation so as to always consider the possible contributions of biological, psychological, and sociological factors relevant to the patient's condition. In every case, however, a psychosocial assessment should be part of the patient's evaluation. If a detailed assessment of the patient's personality structure is indicated, this is often best performed by a psychoanalyst or psychodynamically oriented psychotherapist. The theoretical basis for such

assessments are primarily based on psychoanalytic theory that is discussed in depth in a chapter in the companion text to this volume on human behavior (Inderbitzen and James, 1994).

## THE PRIMARY PHYSICIAN'S ROLE IN PSYCHOSOCIAL ASSESSMENT

It should be emphasized that a complete psychosocial assessment may be a complex and time-consuming process. In many cases, performing such an evaluation will exceed the skills and time of even the most psychologically minded physician. In such situations it may be necessary to refer the patient to a psychiatrist for a more in-depth assessment. Nevertheless, it is still the responsibility of the primary physician to gather certain basic information to assess and identify patients who may need referral.

The responsibility of the primary physician to elicit basic psychosocial data in this situation has analogies in general medical practice. For example, a general internist will assess the signs and symptoms of a patient with chest pain and, after this initial assessment, might then refer the patient to a cardiologist for possible cardiac catheterization and definitive cardiologic diagnosis and treatment. The internist would hardly consider initiating such a referral without gathering the basic medical history and performing a physical examination. Similarly, gathering basic psychosocial information about the patient will assure that patients in need of more specialized evaluation will be identified appropriately.

## PSYCHOSOCIAL ASSESSMENT: BASIC APPROACHES

When the psychosocial assessment is conducted, there are several fundamental questions that should be posed to the patient, and if adequate time is allowed for exploration of the patient's responses, an excellent initial data base can be assimilated by the primary physician regarding the patient's general developmental history and current psychosocial status.

For example, the physician may ask questions directed toward determining the key events and important people in the patient's childhood, adolescence, and adulthood that appear to have had or continue to have an effect on the patient. Were there past traumas, losses, or problems within the family system, or difficulties in other childhood and adult relationships that had a major impact on the patient? Are there conflicted or unresolved relationships with family, friends, or significant other individuals that are a source of distress for the patient? Have there been particularly difficult times in the patient's life? What have been the patient's sources of happiness and satisfaction or unhappiness and frustration? Answers to open-ended questions of this sort will usually yield information that will form the rubric of a preliminary psychosocial and psychodynamic understanding of the patient. Patients who are guarded or who deny the significance or importance of psychological matters will require more

extended psychiatric evaluations, or the physician will need to gather information from other sources such as family members.

## PSYCHOSOCIAL STRESSES AND SOMATIC SYMPTOMS

Many patients under psychosocial stress in the general medical setting will present to their primary care physicians with somatic symptoms (insomnia, headaches, gastrointestinal distress). Somatic symptoms are also extremely common and may develop as a response to even minor stresses (e.g., tension headaches). Patients will also seek help in the medical sector for somatic symptoms that are part of a major depressive disorder long before the symptoms are recognized or considered as part of a primary psychiatric syndrome.

### Somatothymia

Some patients have a limited capacity to describe their feelings verbally. This limitation in the ability to articulate and communicate feeling states in verbal language has been termed *somatothymia*, a term derived from Greek terms to mean "a bodily state of feeling." Research in child development has shown that the fundamental "language" children use to communicate physical or emotional distress is in somatic or physical terms. It is only later in development that children begin to learn "feeling" words to label and verbally communicate internal emotional distress, fear, or—alternately—their affectionate feelings. In some individuals, because of cultural, educational, intellectual, familial, and psychological factors, the ability to articulate and communicate emotional states is never developed or is developed to a very limited degree. The multiple determinants of the capacity for affective language have been discussed in detail elsewhere (Stoudemire, 1991a, b).

In some cultures the *primary* means of communicating emotional distress remains based on the use of somatic language. The tendency to describe strong emotional reactions persists in our own culture ("the news just made me *sick*"; "he died of a *broken heart*"; "the news gave me *great pain*"; etc.). Hence, the capacity for directly communicating emotional distress in abstract "psychological" language varies from individual to individual and is subject to strong cultural and subcultural influences. The task of the physician is to learn the "emotional language" of the patient and to interpret it appropriately. For many patients, the language of emotion will continue to be predominantly based on somatic or physical words. The concept of somatothymia will also be mentioned in respect to the somatoform disorders in Chapter 9 as well as in the somatic presentations of depression in Chapter 7. Particularly in respect to depression, it should be noted that somatic symptoms are the principle way that disturbances in mood present in the medical setting.

### Two Caveats

It should not, however, be assumed that all physical symptoms with a negative medical workup are "psychosomatic" or "stress related" in nature. Two caveats should

always be kept in mind: first, symptoms of medical illness and stress/psychiatrically related symptoms may coexist and be enmeshed; hence, even if stress-related symptoms are identified as such, this does not rule out the possibility of concurrent medical illness. Second, stress and the presence of a concurrent psychiatric illness (such as depression) may greatly magnify the symptoms of clearly documented underlying physical illnesses.

## BIOPSYCHOSOCIAL ASSESSMENT

The DSM-IV system discussed in Chapter 1 (see Chapter 1 Appendix) is used primarily for purposes of description and classification and is based on data that can be documented objectively. Integrating the descriptive approach of DSM-IV with a psychosocial and psychodynamic understanding of the patient, however, is useful in determining what types of psychiatric treatment would be most helpful for the patient, especially in determining the need for psychotherapy.

As mentioned in Chapter 1, the biopsychosocial model uses a systems approach in attempting to integrate biological, psychological, and social aspects of the patient's condition (Alexander, 1950; Bertalanffy, 1968; Cohen-Cole & Levinson 1994; Engel, 1977; Fink, 1988; Meyer, 1957; Reiser, 1988). This approach inherently validates the potential importance of biogenetic, psychological, social, and environmental factors in the diagnosis and treatment of the patient.

The basic clinical principles of the type of biopsychosocially oriented case assessment of patients in medical or psychiatric settings presented in this text would take the following into consideration:

1. Genetic and biological factors are deemed to be of major importance in the pathogenesis and treatment of certain psychiatric disorders (such as schizophrenia and mood disorders) and also may play a part in determining the patient's resilience or vulnerability to stress.
2. Certain problematic developmental experiences and conflicted relationships within the family and social system may confer vulnerabilities to certain types of psychiatric illness; alternatively, positive developmental experiences and relationships and good social support may provide a buffering effect.
3. Current life stresses may precipitate the onset of certain psychiatric disorders and symptoms or contribute to relapses of preexisting conditions.

This chapter focuses on the practical clinical applications of these principles, and space does not permit a critical review of the overwhelming scientific evidence to support the biopsychosocial model. In the companion volume on human behavior for medical students, the scientific basis for the biopsychosocial model is discussed in depth, particularly by Cohen-Cole and Levinson. Students are referred to selected articles in the annotated bibliography and reference list and other chapters in the text on human behavior that precedes this volume for substantiating information (An-

eshensel, Stone, 1982; Bifulco, Brown, Harris, 1987; Birley, Brown, 1970; Bolton, Oatley, 1987; Breier, Kelsoe, Kirwin et al. 1988; Bryer, Nelson, Miller et al. 1987; Cadoret, O'Gorman, Troughton et al. 1985; Coyne, 1991; Dew, Bromet & Penkower, 1992; Doane, West, Goldstein et al. 1981; Galanter, 1988; Goldberg, Bridges, Cook et al. 1990; Greenblatt, Becerra, Serafetinides, 1982; Harris, Brown, Bifulco, 1986, 1987; Kendler, 1988; MacMillan, Gold, Crow et al. 1986; Miklowitz, Goldstein, Neuchterlein et al. 1987; Miklowitz, Goldstein, Neuchterlein et al. 1988; Miller, Ingham, Davidson, 1976; Parry, Shapiro, 1986; Pellegrini, 1990; Penkower, Bromet, Dew, 1988; Romans, Walton, Herbison et al. 1992; Roy, 1980; Rutter, 1985; Schwartz, Myers, 1977a & b; Stansfeld, Gallacher, Sharp et al. 1991; Tennant, 1983, 1988; Tennant, Bebbington, Hurry, 1982; Tennant, Hurry, Bebbington, 1982a & b; Tennant, Smith, Bebbington et al. 1981; Uhlenhuth, Paykel, 1973; van der Kolk, 1986, 1994; Weissman, Gammon, John, et al. 1987).

## CLINICAL APPLICATIONS

Diagnosis and treatment using the biopsychosocial model are multimodal and are directed toward stabilizing each sphere of the patient's life that appears to be under stress—biological, psychological, and/or social. To reiterate, in this conceptual framework it is essential to (1) accurately assess the pertinent biological and physical factors associated with the patient's condition, (2) evaluate the effects of past and present environmental, social, and family stressors, and (3) appraise the psychological significance of the illness for the patient (e.g., how the patient experiences the illness in light of significant current and past life experiences).

The following prototypical case describes how the biopsychosocial model, the DSM-IV descriptive approach, and a psychosocial/psychodynamic formulation can be integrated into patient evaluation and comprehensive treatment planning.

### CASE STUDY: MR. A

*Mr. A, a 50-year-old married attorney, presented to his internist 4 weeks after successful coronary artery bypass surgery. He appeared to have deteriorated after his successful surgery, was chronically fatigued, had severe insomnia, had lost his appetite, and had lost interest in doing almost everything, including returning to work. Because of his inability to return to work, he was sinking into financial debt, and his position in his law firm was in jeopardy. Although he had little interest in sex, he did attempt intercourse with his wife several times but was impotent.*

*The internist performed a complete medical evaluation and checked his laboratory profile. He was slightly hypokalemic because of the use of a thiazide diuretic. He was also taking the beta-adrenergic blocking agent propranolol for hypertension. Other than being overweight and continuing to smoke two packs of cigarettes a day, his examination was unremarkable, including a screening thyroid profile.*

*The internist assessed that the patient was primarily depressed, so he tapered and discontinued his propranolol (the physician knew the drug*

has been associated with inducing depression). He "reassured" the patient and prescribed a low dose of a cyclic antidepressant and a benzodiazepine sleeping medication and scheduled a follow-up appointment for 4 weeks.

Despite these measures, the patient continued to deteriorate. He began to have crying spells, guilty ruminations, and suicidal thoughts. He took his antidepressant inconsistently. He returned to the internist after a week at his wife's insistence. The internist felt a psychiatric consultation was then necessary.

The psychiatrist evaluated the patient and, because the patient had recently had an extensive physical and laboratory evaluation, he decided to begin treatment with a cyclic antidepressant with incremental increases, giving no more than a week's supply at a time because of the possibility of a suicidal overdose. Because the patient's wife could stay with him during the day and the patient denied any suicidal plans, the decision was made to treat him initially as an outpatient with twice-weekly visits.

Before deciding on this treatment plan, however, the psychiatrist first performed a full psychiatric history and mental status examination. The patient was found to be cognitively intact and his symptoms were all consistent with the diagnosis of major depression. The patient's personality assessment revealed marked obsessive-compulsive traits in that he was a "workaholic," a perfectionist, driven to achieve, and rarely ever "relaxed." He was generally rigid and strict with his children and emotionally aloof. Although he loved and was devoted to his family, he had severe difficulty in directly expressing any affection or personal feelings toward them or other people. Although things had gone well for him professionally, he believed he was never totally happy and had a tendency to be chronically mildly depressed, dysphoric, and dissatisfied with himself and life in general. He never believed he had "done enough" professionally and always thought he had to prove himself to others, and he had doubts about his basic self-worth. He had marked difficulties in expressing not only affectionate feelings but anger as well. When angry, he would generally "bottle it up," become preoccupied with the person or situation he was angry with, and "stew" for days.

Exploration of his developmental history revealed that his mother was generally available to him, but she had periods of apparent depressive episodes that were disabling, and she would emotionally withdraw from the family. She had never sought or received professional treatment for these apparent depressive episodes. His father was emotionally remote, cold, critical, and "pushed him" to do well in school. Because of the pressure and criticism from his father (and the fact that he felt he had to "earn" his father's love and approval), he gradually became more distant from him, silently resenting him, and sometimes "wished he were dead."

*His father died suddenly of a myocardial infarction at age 49 when the patient was 15. The patient described his father's death as traumatic, not only because of the loss of his father but because he felt as if the anger and hostility he felt toward his father "had something to do with his death." Although he realized that this was not rationally possible, he nevertheless felt guilty about having been angry at his father and felt that he had to make it up to him "in some way." In addition, he felt that when his father died he had forever lost the chance to be close to him.*

*The patient ultimately went on to finish high school and college and decided to become an attorney, similar to his father. The patient always had a fear of dying at an early age—of a heart attack, similar to his father—but nevertheless smoked, was overweight, and did not exercise.*

*Based on the patient's chronic history of depression, the psychiatrist believed that in addition to his antidepressant treatment, the patient could benefit from psychotherapy. The psychiatrist, who had a psychodynamic orientation, initially formulated the patient's case as follows: Part of the patient's problems with depression and low self-esteem were associated with problematic relationships with his parents. His mother's periodic depressions would, at times, make her unavailable to him when the patient needed support as a child, and he often interpreted her lack of interest and responsiveness as a sign of rejection. Moreover, his father was hypercritical and demanding, leaving the patient with feelings of worthlessness and guilt when he did not perfectly please his father, and he was frustrated by his inability to be close to him. In addition to this frustration, he was also resentful and angry and hated his father at times, although he also loved him and craved his attention and approval. When his father died, the patient was stricken with not only a sense of loss but also remorse and guilt. His guilt centered on his hostility toward his father in that he may have unconsciously related his father's death to his hostile feelings and blamed himself for it.*

*Because both parents often were unavailable to him emotionally and communication of feelings in the family was poor, he felt trapped with his loneliness and did not know to whom or how he could express his inner feelings. Because of his guilt and pattern of having to "achieve" and produce to maintain his self-esteem, he gradually became more engrossed in school and work. His compulsive work habits also served to help him avoid his inner feelings of mild depression and contributed to his compulsive personality traits. The patient nevertheless channeled his compulsive style and need for achievement into his work and did well academically and professionally. His marriage was generally stable, although his wife felt that he was always emotionally remote from her, neglected the family for his work, and could not express his feelings. He tended to be distant, hypercritical, and demanding of his own children, repeating the pattern of his own father. He had drifted further and further from both his wife and children.*

*The psychiatrist believed that the patient's own heart attack could have reactivated the memories and feelings associated with the grief surrounding his father's death. The patient may have identified with the father, and his own heart attack fulfilled his lifelong fear that he too would die at an early age. The psychiatrist also believed that the patient was at high risk genetically for depression because of his mother's probable history of depression and the patient's use of the beta-adrenergic blocking agent propranolol. Both of these factors may have contributed to his biological vulnerability to depression, as may have the acute stress of his coronary artery bypass surgery.*

*In the course of the patient's subsequent psychotherapy, the memories and feelings related to his childhood experiences were explored. The patient gained a new understanding of the impact that his father's death had on him and came to fully realize that his angry feelings toward his father were largely justified and had nothing to do with his father's death; thus, his sense of guilt, which had been largely unconscious, was relieved. He began to realize more fully how he was still trying to "earn" approval by way of work and achievement, a central conflict related to his need to be close to his father and earn his love.*

*Concurrent with his psychotherapy and antidepressant medication, the patient was referred to a cardiac rehabilitation program, where he was placed on a diet, an exercise regimen, and a smoking cessation program. Brief office counseling with the patient's wife reassured them both about the safety of gradually resuming normal sexual activity.*

*The patient complied with this multimodal approach and responded well to his antidepressant, psychotherapy, and cardiac rehabilitation program and returned to work. Formal psychotherapy was terminated after 6 months, although he continued on his antidepressant for 1 year, after which it was gradually tapered and discontinued. The patient did well subsequently.*

## DIAGNOSIS AND BIOPSYCHOSOCIAL ASSESSMENT

In the DSM-IV schemata, the patient would have initially been diagnosed as follows:

Axis I: Major depression, single episode, severe, without psychotic features

Dysthymic disorder, primary type, early onset (provisional diagnosis)

Nicotine dependence

Axis II: Obsessive-compulsive personality traits (premorbid)

Axis III: Coronary artery disease, status post coronary artery bypass surgery; Status post hypokalemia, essential hypertension, overweight

Axis IV: Psychosocial and Environmental Problems: Occupational Problem (threat of job loss)

Axis V: Global Assessment of Functioning (GAF): 45

The biopsychosocial assessment applied to this case provided a structured and systematic way of understanding the patient's condition by attributing significance to each sphere of his life—psychological, biological, and social—as well as understanding key developmental influences that affected the patient's personality development and vulnerability to depression (Fig 2-1). In this manner, the treatment interventions that were devised (medical/biological, psychotherapeutic, and rehabilitative/social) addressed *each aspect* of the patient's life and sources of stress. Hence, the descriptive approach of DSM-IV, which is based clearly on the biopsychosocial model with its multiaxial system, combined with a basic psychodynamic assessment that attempts to analyze the meaning of an illness for patients from the standpoint of both past and current life experiences, provides a comprehensive method to formulate an integrated plan of treatment. Table 2-1 summarizes a structured treatment approach to psychiatric assessment and treatment planning based on this approach.

Although the relative *weight* attached to biological, psychological, and social aspects of each individual patient varies, it is essential that each area at least be considered to be potentially important. This philosophy and approach to patient care is the essential theme that runs throughout the course of this text.

In the remaining chapters of this text, students will become familiar with major psychopathological syndromes in clinical psychiatry and the management of behavioral and psychiatric disorders that are encountered in medical, surgical, and pediatric

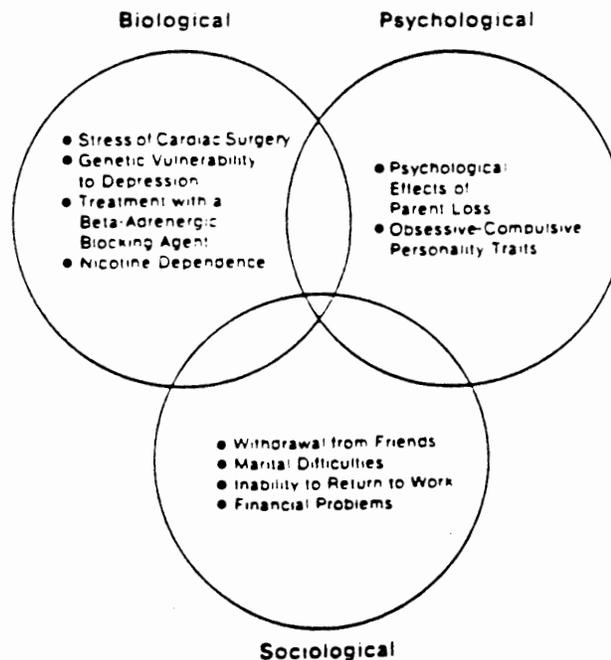


Figure 2-1. The interaction of biological, psychological, and social factors in the case of Mr. A.

Table 2-1 **Outline of Psychiatric Assessment and Treatment Planning**


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Psychiatric history
Mental status examination
Medical evaluation
Differential diagnosis—psychiatric and medical
DSM-IV diagnoses (definitive or provisional)
Psychiatric disorders (Axis I)
Personality diagnosis (Axis II)
Medical diagnoses (Axis III)
Identification of major psychosocial stressors (Axis IV)
Assessment of psychosocial functioning (Axis V)
Psychosocial assessment and case formulation
Treatment plan
Psychological—need for and choice of psychotherapy, inpatient or outpatient treatment
Biological—need for further medical/neurological evaluation or treatment, psychopharmacological treatment, rehabilitation programs
Social—need for intervention in environmental conditions and social conditions, referral to support agencies, occupational counseling, financial or legal assistance

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settings. As the student studies these conditions and encounters them in his or her future medical practice, it is hoped that they will take an integrated approach to patient assessment and treatment based on the biopsychosocial model presented in these introductory chapters.

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### **CLINICAL PEARLS**

The following ten questions, which should be modified by the interviewer to be asked in an open-ended manner, will facilitate uncovering the source of psychosocial stress connected with the onset or relapse of psychiatric symptoms, assuming the patient is open and cooperative with the interviewer.

- Has there been any recent serious illness or death in your family?
- Have you been having any problems with money or with your job? Are you seriously in debt?
- Have you had any serious problems with your children, your marriage, or other close relationships?
- Have you had any recent illness or surgery, and are you on any medications?
- Have you ever thought you might have a problem with drinking too much alcohol or taking drugs?
- Have you been under any stress or pressure recently that has been difficult for you to manage?

Regarding the patient's past history, the following questions will help identify any significant psychodynamic problems or major stresses in the patient's developmental years. These are "lead" questions that will identify any major developmental traumas, but the development history should not be limited solely to these four questions.

- Tell me about growing up with your family and your relationship with your parents. Did you have any special problems with your parents or within your family when you

- were growing up? Was there frequent fighting between your parents when you were a child or teenager?
- Did either one of your parents have a problem with alcohol or drugs?
  - Did your parents divorce or separate when you were a child, or did one of your parents die when you were young?
  - Were you ever physically or sexually molested when you were a child or teenager?

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This is an intriguing and beautifully written text that remains a classic as an introduction to psychodynamic theory.

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Balint was a psychoanalyst who worked extensively with primary care doctors in evaluating and treating the common psychiatric conditions of general medical patients. This text remains a classic for exploring and understanding the psychological aspects of medical practice.

For students interested in excellent resources on psychiatric interviewing, the following books are recommended.

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## Treatment Planning

apy; inpatient or outpatient

valuation or treatment;  
programs

tions and social conditions; re-  
t, financial or legal assistance

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by the interviewer to be asked  
source of psychosocial stress  
comes, assuming the patient is

your family?  
in your job? Are you

your marriage, or other

on any medications?  
drinking too much alcohol

that has been difficult for

years will help to identify any  
in the patient's developmental

major developmental trauma  
to these four questions

relationship with your  
parents or within your

fighting between your  
alcohol or drugs

childhood one of your  
to have a child or teenager

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