

1. CONCEPTUAL BASES: HISTORICAL, CULTURAL, AND CLINICAL PERSPECTIVES

Guidelines

- 1.1 Diagnostic Assessment is the process of appraising a patient's condition. It involves effectively engaging the patient in order to obtain accurate information relevant to understanding health problems (mental and general medical disorders), their context (psychosocial and environmental problems) and their impact on adaptive functioning and participation in society (i.e. disablements). A comprehensive diagnostic formulation represents a summary of the clinician's judgement about the overall condition of the patient, obtained as much as possible with his/her collaboration. The main purpose of diagnosis is to serve as the basis for clinical care. Further objectives include to communicate concisely and reliably information on health problems, to understand their biopsychosocial pathogenesis and the interaction of internal and contextual factors, to enhance training and research, and, last but not least, to inform a collaborative process of care aimed at the restoration and promotion of health, functioning and quality of life.
- 1.2 A mental disorder is conceived in these Guidelines as a recognizable set of clinical symptoms and behaviors associated in the majority of cases with suffering, psychic disharmony, and interference with adaptive functioning and participation in social life. This concept is incorporated in standard classifications of mental disorders, e.g., Chapter on Mental and Behavioral Disorders of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) (WHO, 1992), Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV) (American Psychiatric Association, 1994), Chinese Classification of Mental Disorders, 2nd Ed. Revised (CCMD-2R) (Chinese Medical Association, 1995), and Third Cuban Glossary of Psychiatry (Otero-Ojeda, 2000).
- 1.3 Other concepts integral to a comprehensive diagnostic formulation include the following:
 - General Medical Conditions are health problems that are not classified as mental or behavioral disorders. General medical conditions may have emotional components and mental disorders may have somatic elements.
 - Disabilities refer to limitations or problems in adaptive functioning. Such limitations occur in self-care, interpersonal functioning, occupational performance, and participation in society.
 - Psychosocial and Environmental Problems are contextual factors or situations affecting the emergence or course of illness and requiring clinical attention and intervention.
- 1.4 A comprehensive diagnostic formulation and its theoretical framework, as all human constructions, are products of their time and circumstances. Therefore, the clinician

should be aware that they reflect historical developments, cultural factors, ethical norms, and clinical and epidemiological requirements at a particular point in time.

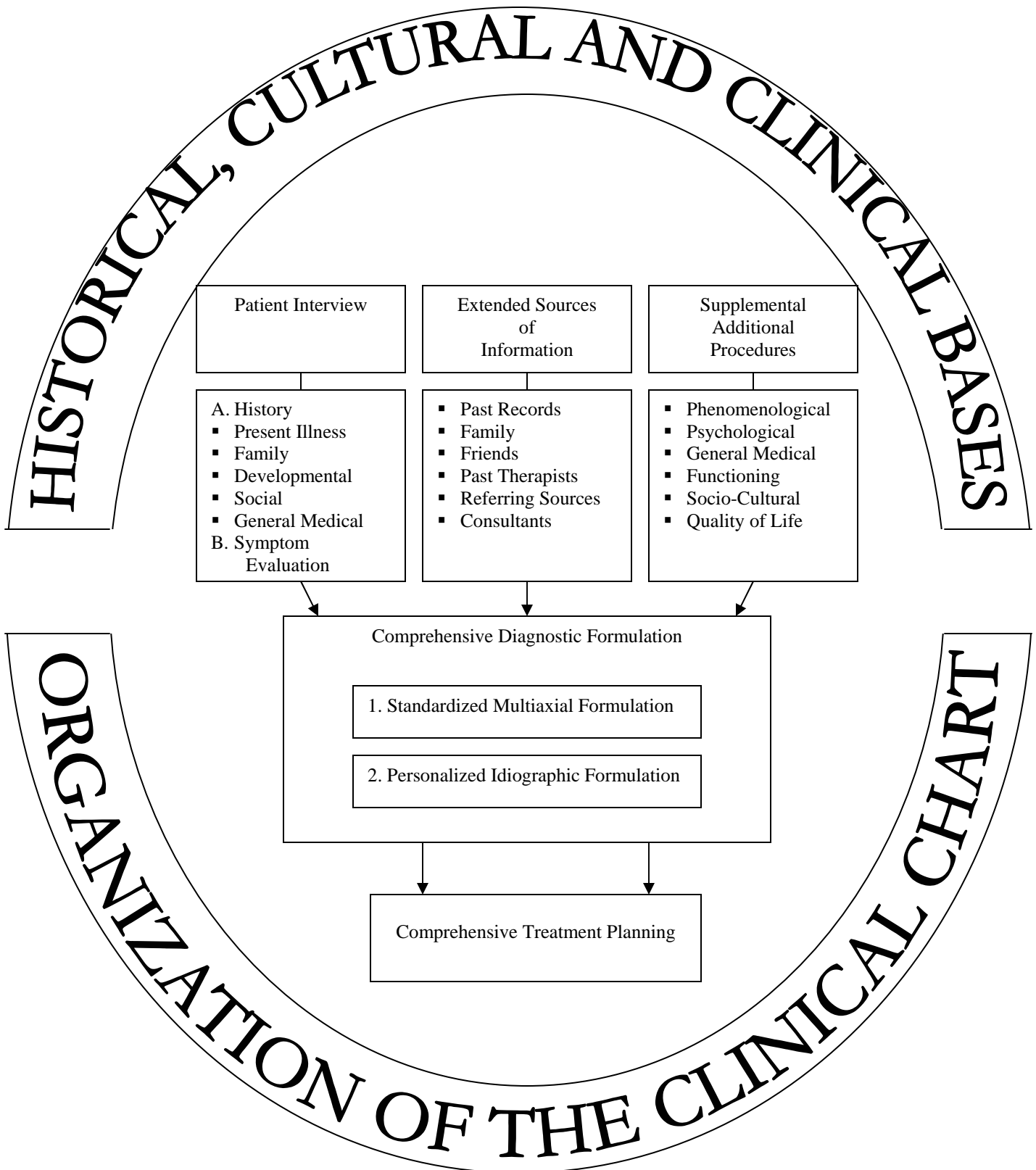
- 1.5 The psychiatric interview is the single most important part of the diagnostic evaluation process. It affords the means to establish rapport and to elucidate clinical data by listening to and probing the patient and observing his/her behavior. The interview is the main source of information on the course of the condition, the personality of the patient, his or her biography, adaptive functioning and environmental and psychosocial stressors. It is also the basis of the idiographic (personalized) evaluation of the patient. The interview is conducted according to professionally accepted rules and ethical standards, and requires appropriate training.
- 1.6 The clinician must consider other sources of information, besides the clinical interview. This is essential in special circumstances that prevent the patient from providing information. Records of previous hospitalizations and outpatient treatment are usually important to consult. Other sources, e.g., relatives, friends, neighbors, police, should be consulted, whenever appropriate, with the patient's consent and assuring confidentiality in their use.
- 1.7 All patients presenting for psychiatric care should receive a comprehensive evaluation of symptoms and mental status. A basic physical evaluation is advisable, which, when necessary, should include a physical examination. All psychopathological terms should be used in a reliable and comparable way, and all areas of psychopathology should be described in a systematic and standardized manner. Supplementary assessment procedures are further sources of information, which range from specialized physical evaluation, laboratory tests and imaging procedures to structured or standardized instruments for the assessment of the clinical condition. The clinician should be familiar with them and with the prerequisites for their use.
- 1.8 The diagnostic process involves more than identifying a disorder. Positive aspects of health, such as personal and social assets and quality of life, should also be described. Concerning the presentation of diagnosis, a nomothetic or standardized diagnostic formulation (e.g. ICD-10, DSM-IV) is to be combined with an idiographic or personalized diagnostic formulation, reflecting the individuality and uniqueness of the patient's personal experience. At the nomothetic level, a multiaxial diagnostic formulation is recommended. For the idiographic formulation, an integration of the perspectives of the clinician, patient and family should be presented in natural language.
- 1.9 The main objective of diagnosis is patient care. A care plan should be prepared on the basis of both the multiaxial formulation of the patient's condition (taking into account clinical disorders present, disablements, contextual factors, and quality of life) as well as the idiographic diagnostic formulation (e.g., patient's needs and expectations, cultural factors and economic and therapeutic resources). The program of care should include additional diagnostic studies and specific therapeutic interventions. Evolving longitudinal observations should lead to periodic updating of the comprehensive diagnostic formulation.

- 1.10 A record of information documenting the comprehensive diagnostic assessment should be kept in every individual patient's chart. This information should be presented in an organized format that includes narrative components.

Recommended Readings:

- Barron, J.W. (Ed.) (1998): Making diagnosis meaningful. Washington, DC: American Psychological Association.
- Mezzich, J. E., Kleinman, A., Fabrega, H., Parron, D. L. (Eds.) (1996). Culture and psychiatric diagnosis: A DSM-IV perspective. Washington, D. C.: American Psychiatric Press.
- Misés, R., Fortineau, J., Jeammet, P., Lang, J.-L., Mazet, P., Plantade, A., Quémada, N. (1988): Classification Francais des Troubles Mentaux de L'Enfant et de L'Adolescent (French Classification of Mental Disorders of Children and Adolescents). Psychiatrie de L'Enfant, 31, 61-134.
- Zadler, J. Z., Wiggins, O. P., Schwartz, M. A. (1994). Philosophical perspectives on psychiatric diagnostic classification. Baltimore: Johns Hopkins University Press.
- Zheng, Y. P., Lin, K-M, Zhao, J. P., Zhang, M. Y., Young, D. (1994). Comparative study of diagnostic systems: Chinese Classification of Mental Disorders, 2nd ed. Versus DSM-III-R. Comprehensive Psychiatry, 35, 441-449.

Figure 1: A Diagrammatic View of Comprehensive Diagnostic Assessment (Section 1)



2. INTERVIEWING THE PATIENT

Guidelines

- 2.1 An appropriate setting for the psychiatric interview should be selected or arranged within the circumstances available. It should optimize comfort of the patient and the interviewer, protect privacy and minimize external distractions.
- 2.2 The clinician should establish trusting rapport with the person by introducing him/herself, greeting the person appropriately, explaining the purpose of the interview, ensuring confidentiality to the extent possible, and communicating an intention to be of help.
- 2.3 The interview is a dynamic process, involving a clinician and patient, that should lead to mutual understanding, without blurring their respective roles. The clinician should adopt an attentive, interested, listening attitude, convey respect for the person's wishes and dignity, strive to create a naturalistic and conversational flow, and facilitate the engagement of the patient in the interview.
- 2.4 Cultural considerations should inform the conduct of the interview. The clinician and patient should discuss cultural issues and opportunities and language barriers and agree on ways to deal with them. Whenever necessary, competent and thoughtful translators and cultural consultants (without undermining clinician-patient engagement) should be utilized.
- 2.5 The clinician should explore the circumstances leading to the patient's presentation for evaluation and his/her expectations for care. Gaining an understanding of the patient's life history and concerns for quality of life is also important. An effort should be made to encourage the patient to express himself or herself in the way he/she would like to be heard.
- 2.6 Through anamnesis, information should be systematically gathered on the major mental health problems of the patient, including timeframe, mode and circumstances of onset, clinical signs and symptoms, dangerous behaviors, concomitant functional difficulties, relevant contextual factors, illness course, treatment received, and efforts at restoration of health and quality of life (from physical well-being to spirituality).
- 2.7 The clinician should obtain systematic information on other important aspects of the patient's clinical background, including family, developmental, social, occupational, substance use, and general medical histories.
- 2.8 The clinician should endeavor to maintain a collaborative rapport with the patient leading to the formulation of a jointly agreed care plan.
- 2.9 On approaching the end of the interview, the next steps for diagnostic and therapeutic efforts should be specified. Further diagnostic efforts may include, as appropriate, and

with the patient's consent to the fullest possible extent, interviewing family members and other individuals knowledgeable about the patient's condition, as well as using supplementary assessment instruments and procedures.

- 2.10 The clinician should work with the patient towards closing the interview in a manner that promotes in the patient greater self-esteem, a sense of hope, cooperation and clarity on goals, expected progress and the process to follow.

Recommended Readings

Anderson, A. K., Lynch, T. (1996). Listening. Oxford, U. K.: Oxford University Press.

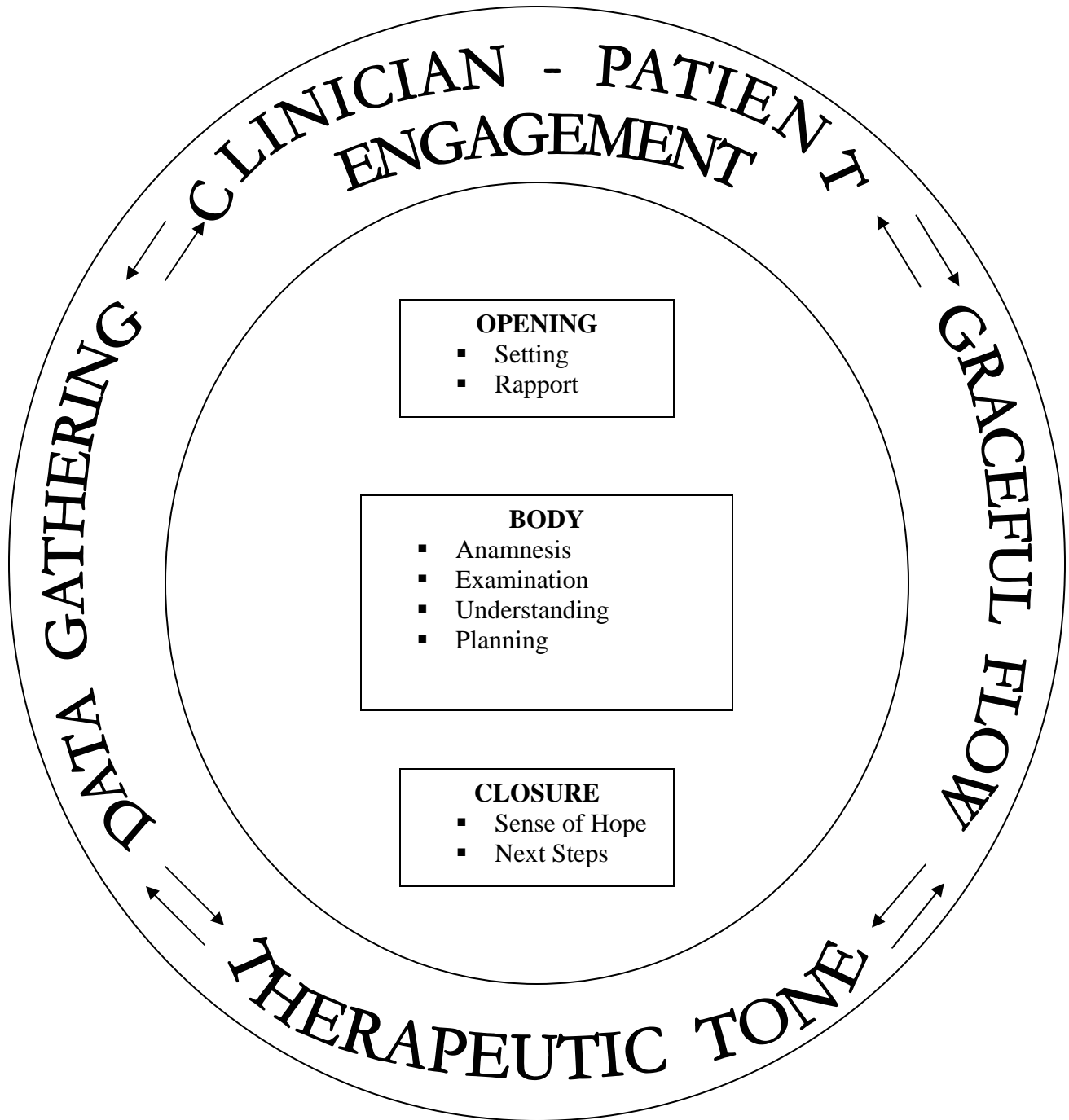
Deniker, P., Féline, A. (1990). Le premier contact et l'observation in psychiatrie (The first contact and observation in psychiatry). In P. Deniker, T. Lempériere & J. Guyotat (Eds.). Précis de psychiatrie clinique de l'adulte. (pp. 5-11). Paris: Masson.

Barcia-Salorio, D., Muñoz-Pérez, R. (1991). The interview in psychiatry. In A. Seva (Ed.). The European handbook of psychiatry and mental health. (pp. 443-458). Zaragoza: Prensas Universitarias de Zaragoza.

Shea, S. C. (1998). Psychiatric interviewing: The art of understanding, 2nd Edition. Philadelphia: W. B. Saunders.

Ward, N. G., Stein, G. (1975). Reducing emotional distance: A new method of teaching interviewing skills. Journal of Medical Education, 50, 605-614.

Figure 2: Interviewing Process (Section 2)



3. USE OF EXTENDED SOURCES OF INFORMATION: LIVE AND DOCUMENTARY

Guidelines

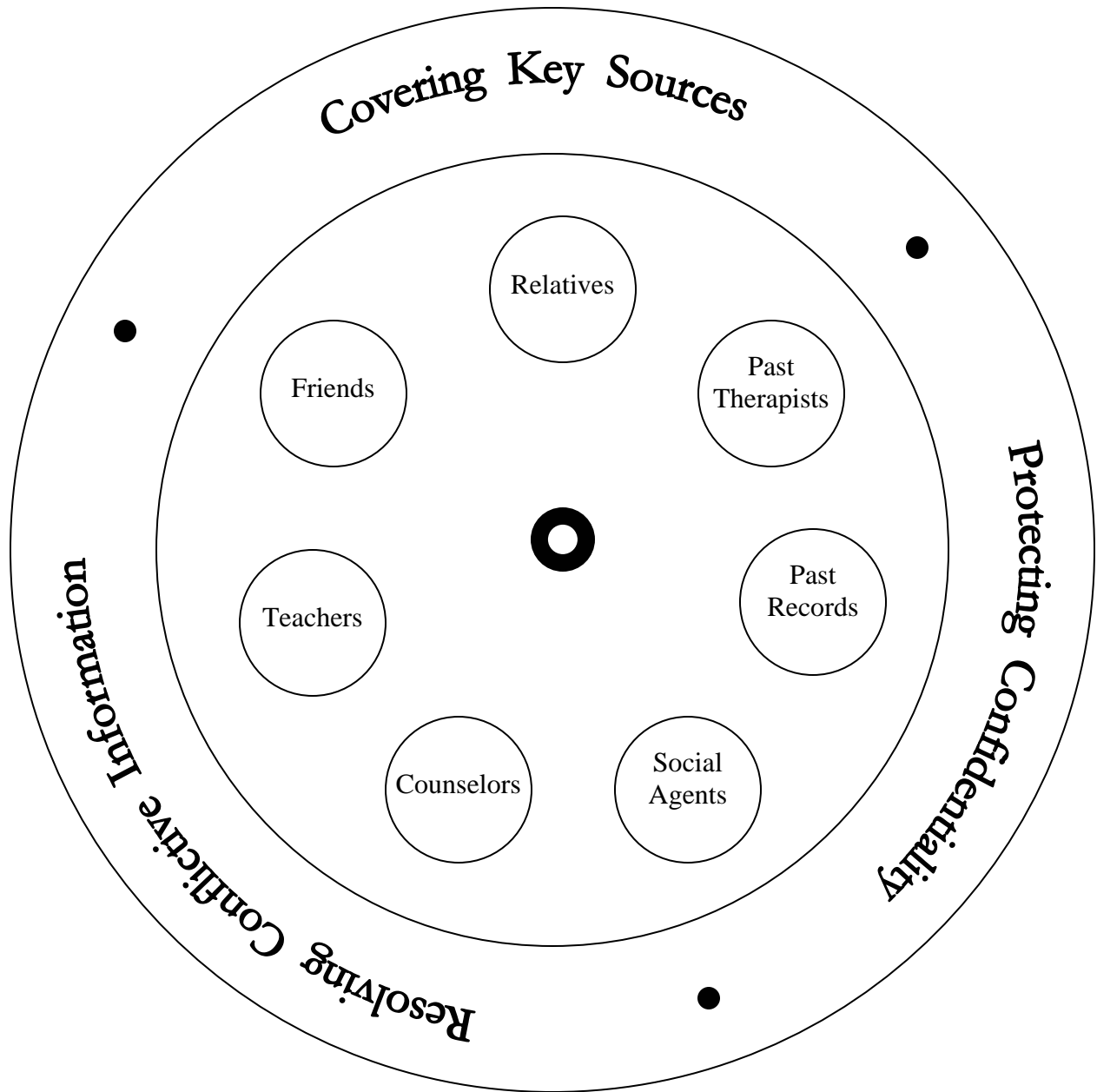
- 3.1 The use of extended sources of information is an important part of the diagnostic process, since they corroborate, complement or correct information provided by the patient him/herself.
- 3.2 Sources of information relevant to the diagnostic enterprise should be selected based on the specific objectives of the evaluation and the particular setting where the assessment is taking place (school, emergency room, police station, detention center, etc). In most cases, the minimal standards on extended sources of information may be to consult the records of any previous treatments and to contact one relevant person.
- 3.3 The use of extended sources becomes even more essential in special circumstances that prevent the patient from providing adequate information; e.g., at the emergency room, when the patient is too young or too old, or when the patient is in a psychotic state, intoxicated or unconscious.
- 3.4 Specific types of data collected through extended sources of information vary according to the type of patient and his/her special circumstances. Developmental history, family history, diagnoses made during previous hospitalizations, and current functioning are examples of data that frequently the patient is not able to provide fully and require the use of extended sources of information.
- 3.5 The need to use other sources of information should be discussed with the patient and his/her consent should be requested whenever possible and in accordance to cultural norms. Specific thoughts and feelings the patient may have about these sources should be explored. The patient should be assured of confidentiality to the fullest extent possible. This may be especially critical in circumstances where revealing a family secret may have serious consequences for the patient's relationship with his/her primary support group. Whenever confidentiality on the part of the clinician requires to be limited, this should be made explicit.
- 3.6 If the patient is a young child, the clinician should interview the parents, other caretakers, teachers, camp counselors, school psychologists, pediatricians, other relatives, and all those who can provide information about the current behavior and functioning of the child, and his/ her psychosocial functioning and adaptation.
- 3.7 Information provided by other sources should be treated with the same thoughtful and critical attitude used for information provided by the patient. One must remember that information offered by other sources is not the ultimate truth about the condition of the patient, but a different perspective, and it might be in fact another source of unreliability.

- Clinical judgment and experience should be displayed to sort out sources of unreliability, and to adequately weigh the diagnostic value of all collected data.
- 3.8 Confidentiality should be assured to the person giving information, to the fullest extent permissible by law and local customs. One must be aware that he/she could be involved in a conflictual relationship with the patient.
 - 3.9 The patient's records, the records of relatives, as well as judicial, social, counseling and educational records are all examples of useful documentary sources of information. Usually consent by the patient is necessary to consult these sources.
 - 3.10 Past records may be helpful but they should be reviewed with a critical attitude. For example, when using old records one must be attentive to diagnostic practices prevalent at the time when such records were prepared. For instance, cases of bipolar disorder or borderline personality could have erroneously been diagnosed before as schizophrenia.

Recommended Readings

- Bird, H. R., Gould, M. S., Staghezza, B. (1992). Aggregating data from multiple informants in child psychiatry. Journal of the American Academy of Child & Adolescent Psychiatry, 31, 78-85.
- Herjanic, B., Herjanic, M., Brown, F., Wheatt, T. (1975). Are children reliable reporters? Journal of Abnormal Child Psychology, 3, 41-48.
- Lavretsky, E. P., Jarvik L. F. (2000). Psychiatric examination of the older patient. In B. J. Sadock & V. A. Sadock (Eds.) Kaplan & Sadock's Comprehensive textbook of psychiatry. 7th ed. Vol. 2. (pp. 2998-3010). Baltimore: Williams & Wilkins.
- Reich, W., Earls, F. (1987). Rules for making psychiatric diagnosis in children on the basis of multiple sources of information: Preliminary strategies. Journal of Abnormal Child Psychology, 15, 601-616.
- Rotondo, H. (1998): Orientaciones al estudiante para la historia clínica psiquiátrica (Guidelines for students on the psychiatric clinical history). In A. Perales, A. Mendoza, G. Vásquez-Caicedo, M. Zambrano (Eds.) Manual de Psiquiatría "Humberto Rotondo", 2nd Edición. Lima, Peru: Editorial de la Universidad Nacional Mayor de San Marcos.

Figure 3: Use of Extended Sources of Information (Section 3)



4. EVALUATION OF SYMPTOMS AND MENTAL STATUS

Guidelines

- 4.1 All patients presenting for psychiatric care should receive a comprehensive descriptive psychopathological evaluation. This should include a broad symptomatological assessment specifying the time frames of the findings, as well as a mental status examination at the time of the patient interview.
- 4.2 Five major areas of psychological functioning and psychopathology should be evaluated:
 - Consciousness, orientation, memory, and intellect.
 - Speech, thinking, perception, and self-experience
 - Emotions
 - Physical signs and symptoms of mental disorder
 - Behavior and adaptive functioning
- 4.3 Standardized definitions of terms should be used in describing the elements of psychopathology. Standardized glossaries should be consulted, such as the WHO (1994) Lexicon of Psychiatric and Mental Health Terms and the Schedules for Clinical Assessment in Neuropsychiatry (WHO, 1999).
- 4.4 A comprehensive evaluation documents symptoms elicited or observed during the interview, those present in the recent past and relevant to the current illness, as well as those present during the more distant past and relevant to the past psychiatric history.
- 4.5 The assessment of signs and symptoms requires careful observation of the patient during the interview, listening to the patient's narrative as he/she presents a chief complaint and history, and specific questioning in suspected problem areas. Evidence of signs and symptoms may also come from ancillary information sources, such as records of prior treatment and reports of relatives, friends, representatives of social agencies, and other professionals.
- 4.6 The clinical significance of symptoms should be determined by a consideration of their severity. Severity is reflected in the intensity, frequency, and duration of symptoms, their tendency to cause subjective distress, and their impact on the patient's functioning. Symptom severity should be documented. Violent and suicidal ideation and behaviors should be pointedly assessed and documented.
- 4.7 The evaluation of symptoms should be guided by hypotheses about their diagnostic or syndromic significance. Observations and lines of questioning should be based on the identification of major psychiatric syndromes and ruling out specific disorders in differential diagnosis.

- 4.8 Variations in the presentation of psychopathology according to a patient's age, gender, and sociocultural background should be considered in the conduct of the examination and in the interpretation of collected information, e.g., depression tends to present predominantly with somatic symptoms in traditional societies. The significance of any behavior or mentation, as indicative of psychopathology or as culturally sanctioned, should be carefully considered.
- 4.9 The findings of the mental status exam should be summarized according to standard domains, such as the following:
- Sensorium
 - Memory
 - Judgment
 - Insight
 - Speech and thought processes
 - Thought content
 - Perception
 - Mood and affect
 - Appearance
 - Overt Behavior
- 4.10 Attention should be paid to diagnostic criteria (such as those of ICD-10 and DSM-IV) to guide the evaluation of symptoms and mental status and to appraise the significance of their syndromic significance. However, the possibility of cultural and regional variations and of atypical presentations should be considered.

References (Section 4)

World Health Organization (1994). Lexicon of psychiatric and mental health terms. 2nd Edition. Geneva: WHO.

World Health Organization (1999). Schedules for Clinical Assessment in Neuropsychiatry (SCAN). Geneva: WHO.

Recommended Readings

Delgado H. (1993). Curso de Psiquiatría (Course in Psychiatry). Lima, Peru: Fondo Editorial de la Universidad Peruana Cayetano Heredia.

Jaspers, K. (1973). Allgemeine Psychopathologie (General Psychopathologie). 9 Auflage. Berlin: Springer

Lopez-Ibor, J. J., Ortiz Alonso, T., Lopez-Ibor Alcocer M. I. (1999). Lecciones de Psicología Médica (Lessons in Medical Psychology). Barcelona: Masson.

Sims, A. (1995). Symptoms in the mind: An introduction to descriptive psychopathology. 2nd Edition. London: W. B. Saunders.

Skodol, A. E., Shaffer D., Gurland, B. (1997). Psychopathology across the life cycle. In A. Tasman, J. Kay, J. A. Lieberman (Eds.) Psychiatry. (pp. 449-476). Philadelphia: W. B. Saunders.

Table 1: Evaluation of Symptoms and Mental Status (Section 4)

<p style="text-align: center;">Broad Symptomatological Areas (Anamnesis)</p>	<p style="text-align: center;">Major Sections of Mental Status (Examination)</p>
<ul style="list-style-type: none"> • Consciousness, orientation, memory and intellect <i>(e.g. decreased intellectual functioning)</i> 	<ul style="list-style-type: none"> - Sensorium <i>(e.g. inattentiveness)</i> - Memory <i>(e.g. decreased recall)</i> - Judgment <i>(e.g. gross opinionatedness)</i> - Insight <i>(e.g. unawareness of illness)</i>
<ul style="list-style-type: none"> • Speech, thinking, perception and self-experience <i>(e.g. persistent delusions, depersonalization)</i> 	<ul style="list-style-type: none"> - Speech and thought processes <i>(e.g. loose associations)</i> - Thought content <i>(e.g. bizarre ideas)</i> - Perception <i>(e.g. hallucinations)</i>
<ul style="list-style-type: none"> • Emotions <i>(e.g. sadness)</i> 	<ul style="list-style-type: none"> - Mood and affect <i>(e.g. crying)</i>
<ul style="list-style-type: none"> • Physical manifestations of mental disorder <i>(e.g. sleep or weight changes)</i> 	<ul style="list-style-type: none"> - Appearance <i>(e.g. self-neglect)</i>
<ul style="list-style-type: none"> • Behavior and adaptive functioning <i>(e.g. callousness, intentional ineffectiveness)</i> 	<ul style="list-style-type: none"> - Overt behavior <i>(e.g. agitation)</i>