5. SUPPLEMENTARY ASSESSMENT PROCEDURES CONCERNING PSYCHOPATHOLOGICAL, NEUROPSYCHOLOGICAL AND PHYSICAL ASPECTS

Guidelines

5.1 Supplementary assessment procedures may be used to complement the psychiatric diagnostic interview. This section includes procedures for the comprehensive evaluation of mental and physical status of the patient. Psychosocial procedures are considered in Section 6. Psychopathological assessment instruments and biological tests and procedures, neuropsychological tests, among others, are used to enrich or refine data collected in a clinical interview in order to make clinical diagnoses in the standardized multiaxial diagnostic formulation.

5.2 The purposes of these supplementary assessments are as follows:

- To accurately identify and describe signs and symptoms in terms of their type, extent, and severity.
- To increase the reliability and validity of clinical diagnoses, to aide in the process of differential diagnosis, and to identify potential etiologic factors.
- To document patients' cognitive skills and limitations for the purposes of estimating capacity for self-care, treatment adherence, and ability to carry out activities of daily living.
- To identify particular targets and goals for treatment and rehabilitation and to measure change over time and treatment outcome
- To document psychological and behavioral injuries, rehabilitation potential, and need for treatment; capacity pertinent to legal proceedings.
- To support research on mental disorder evaluation, treatment, and etiology.

5.3 Various types of supplementary assessment procedures should be considered for use, including self- and observer-rating scales, screening tests and scales, symptom and diagnostic checklists, semistructured and fully structured diagnostic interviews, neuropsychological tests, and biological tests and procedures.

5.4 Choice of a supplementary assessment procedure should be based on a number of criteria including the specific purpose intended (e.g., syndrome identification, symptom severity, clinical change over time); domain(s) of pathology (e.g., depression, dementia, personality functioning); characteristics of the patient to be tested (e.g., age, educational level, cognitive status); characteristics of the setting in which the procedure will be used (e.g., primary care practice, psychiatric hospital, community survey); qualifications and training of user (e.g., psychiatrist, general medical professional, lay interviewer); culture of the patient and the evaluator (e.g., first language, translations, concepts of health and illness); psychometric properties of the instrument or procedure (e.g., reliability, validity); cultural validation in the population of interest; and other characteristics (e.g., time frame of interest, time and cost of administration, training required).

5.5 Diagnostic checklists and interviews are useful for trained clinicians to ensure that adequate information has been gathered from the patient, informants, or other sources, so that a differential nosological diagnosis according to specified diagnostic criteria (e.g., those of ICD-10, DSM-IV, Chinese Classification of Mental Disorders) can be made.

5.6 Brief screening scales or instruments that include exploratory questions and symptom or diagnostic checklists are useful when large numbers of patients or community residents are to be examined for possible mental or physical disorders, with positive cases referred for more extensive evaluation. Primary care physician- and lay-administered instruments are useful when a mental health clinician is not available. Rating scales with psychopathological symptoms or syndromes identified with Likert-type or visual analogue scales of frequency or severity are useful to ascertain initial levels of symptom severity and to measure change over time.

5.7 The assessment of psychodynamic and behavioral/cognitive perspectives on psychopathology should be considered, through systematic procedures, especially when these assessments are contributory to a better understanding of the clinical condition or to treatment planning.

5.8 Neuropsychological assessment helps to ascertain mental and neurological factors and causes of symptoms and disorders and to localize sites of lesions. Neuropsychological tests also appraise cognitive strengths and weaknesses and other behavioral capacities of the patient for the purpose of planning treatment/rehabilitation.

5.9 The physical examination and laboratory tests (e.g., blood, urine) are useful to rule in or out general medical conditions or substances of abuse as etiologic for mental disorders and also to aide in the diagnosis of other physical conditions or disorders that may affect treatment or clinical management. Brain imaging (e.g., CT scans, MRI) is useful to document structural and functional brain abnormalities. Electrophysiological tests such as EEG, are useful for documenting abnormal brainwave activity. All of these procedures aid in the process of formulating a more definitive clinical diagnosis.

5.10 The effective use of supplementary psychopathological, neuropsychological, and biological assessment procedures requires appropriate training in their application. The competent interpretation of the results requires training in and familiarity with indications for use, applications to particular patient groups and settings, and strengths and weaknesses of the procedures involved.

Recommended Readings

American Psychiatric Association (2000). Handbook of Psychiatric Measures. Washington, D. C.: Author.

Bech, P. (1993). Rating scales for psychopathology. health status and quality of life: A compendium on documentation in accordance with the DSM-III-R and WHO systems. Berlin: Springer.

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Robin, L. N., Wing, J., Wittchen, H.-U., Helzer, J. E., Babor, T. F., Burke, J., Farmer, A., Jablensky, A., Pickens, R., Regier, D. A., Sartorius, N., Towle, L. H. (1988): The Composite International Diagnostic Interview. An epidemiologic instrument suitable for use in conjunction with different diagnostic systems and in different cultures. Archives of General Psychiatry, 45, 1069-1077.

Sartorius, N, Jança, A. (1996). Psychiatric assessment instruments developed by the World Health Organization. Social Psychiatry and Psychiatric Epidemiology, 31, 55-69.

6. SUPPLEMENTARY ASSESSMENT PROCEDURES CONCERNING FUNCTIONING, SOCIAL CONTEXT, CULTURAL FRAMEWORK AND QUALITY OF LIFE

Guidelines

6.1 Supplementary assessment procedures in this section can be used to obtain a comprehensive assessment of social, cultural, and other contextual factors influencing the occurrence, presentation, course, or treatment of clinical disorders. They may also be useful for measuring social and occupational functioning and participation, social support, family adjustment, life events, and quality of life. In these, as in all clinical assessments, cultural framework should be systematically considered.

6.2 The purposes of these supplemental assessments are as follows:

- To document areas and degrees of impairment in social and occupational functioning for the purposes of comprehensive diagnosis, prognosis, care planning and disability compensation.

- To describe patients' social support systems or networks, personal and environmental resources, and recent and remote stressful life events for the purposes of diagnosis and treatment.

- To assess family's perceptions of a patient's problems, their impact on the patient, and their consequences for family functioning.

- To assess quality of life for a broad assessment of well being and to ensure that attention is paid to what is most meaningful to the patient (e.g., family supports, religious beliefs).

6.3 Various types of supplementary assessment procedures should be considered for use in evaluating these domains including clinician-, self-, and family-rated scales, checklists, and semistructured interview methods.

6.4 Choice of a supplementary assessment procedure should be based on a consideration of the purpose intended (e.g., to aid in determining level of treatment needed, to identify particular targets of treatment); the breadth vs. specificity desired (e.g., global assessment of functioning vs. specific measure of social functioning); the kind of patient or setting of evaluation (e.g., adults with schizophrenia, marital couples, persons in institutional care), and the resources available (e.g., trained interviewer vs. clerical scorer of self-report questionnaire).

6.5 Global assessment instruments provide an overall rating of clinical state or functioning. A trained clinician is usually needed to make the assessment. The rating is usually made on a single continuous scale and can be used to monitor clinical improvement over time.

6.6 Detailed measures of social functioning are indicated to contribute to the assessment of clinical state and health status and to determine level of care (e.g., inpatient, outpatient, long-term residential treatment). The most important areas to assess are interpersonal functioning, occupational functioning, self-care, and broader social participation, keeping in mind that their relative importance varies across cultures.

6.7 Important areas of social context to be assessed include socio-economic status (for example through head of household's occupation and education), social supports and stressors, and access to care (including financial, insurance, geographic, transportation and cultural barriers).

6.8 Scales and instruments to appraise marital and family functioning as well as sexual health are useful for planning couples and family therapy.

6.9 It is often important, particularly in multicultural societies, to assess the cultural framework of the experience of illness explanations and help-seeking behaviors. Consideration of patient's explanatory models can be valuable for both valid diagnosis and effective care planning.

6.10 The need to broaden the informational base of health status assessment has led to the development of quality of life measures. These refer predominantly to the individual's subjective perception of satisfaction with and position in life in relation to his/her goals, expectations, standards and aspirations.

Recommended Readings

Goldman, H. H., Skodol A. E., Love, T. R. (1992). Revising Axis V for DSM-IV: a review of measures of social functioning. American Journal of Psychiatry. 149: 1148-1156.

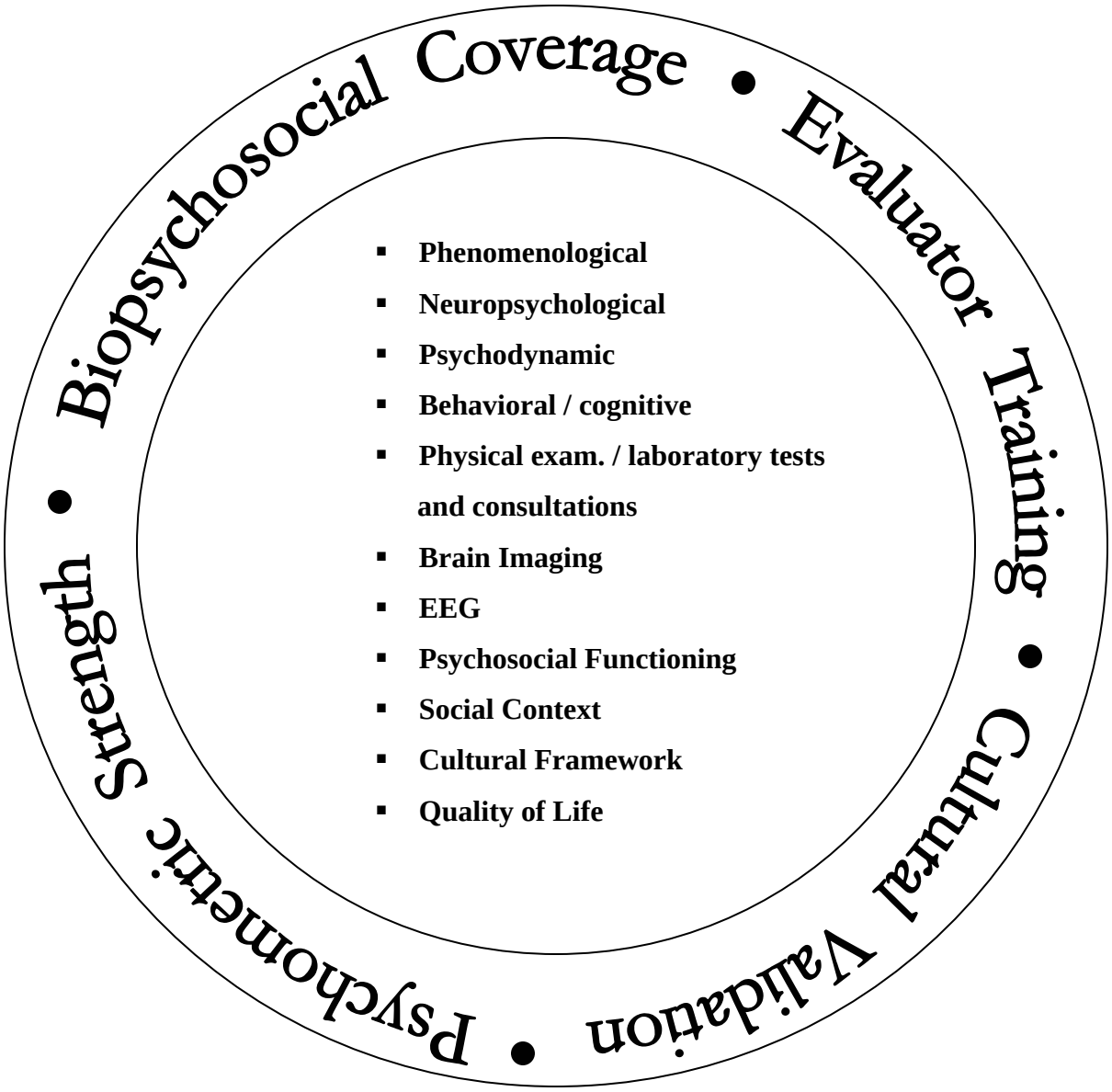
Kabanov, M. M. (1985). Reabilitatsiya psikhicheski bolnykh (The rehabilitation of the mentally ill). 2nd revised edition. Leningrad: Medicine.

Katschnig, H., Freeman, H., Sartorius, N. (1999). La qualita di vita in psichiatria. (Quality of Life in Psychiatry) Roma: Il Pensiero Scientifico Editore.

Weiss, M. G., Raguram, M., Channabasavanna, S. M. (1995). Cultural dimensions of psychiatric diagnosis: a comparison of DSM-III-R and illness explanatory models in South India. British Journal of Psychiatry. 166, 353-359.

World Health Organization (1999). International Classification of Functioning and Disability (ICIDH-2). Geneva, Switzerland: Author.

Figure 4: Supplementary Assessment Procedures (Section 6)



7. STANDARDIZED MULTIAXIAL DIAGNOSTIC FORMULATION

Guidelines

7.1 A thorough and systematic assessment of a patient should lead to a comprehensive diagnostic statement. The first component of this is the multiaxial diagnostic formulation.

7.2 A multiaxial diagnostic formulation provides a contextualized and standardized description of the clinical condition through a number of highly informative, therapeutically significant and systematically assessed axes or domains.

7.3 A tetraaxial formulation, built on the triaxial presentation of ICD-10 (WHO, 1997), is recommended, as follows

- Axis I: Clinical Disorders (Mental and General Medical Conditions).
- Axis II: Disabilities (in personal care, occupational functioning, functioning with family, and broader social functioning).
- Axis III: Contextual Factors (interpersonal and other psychosocial and environmental problems).
- Axis IV: Quality of Life (primarily reflecting patient's self-perceptions)

7.4 Axis I (Clinical Disorders) comprises a list of all relevant psychiatric disorders (including personality and developmental disorders) and general medical conditions that are identified on the basis of a comprehensive historical anamnesis, evaluation of symptoms, mental status examination, supplementary assessment instruments, and the physical exam. Disorders are to be listed in their order of importance for disposition and care.

7.5 Axis II (Disabilities) comprises ratings of impairment in important areas of adaptive functioning. Impairments may be the result of mental disorders, physical disorders, or both. Included are impairments in four separate areas of functioning, as follows:

- Personal care and survival
- Occupational functioning, including roles as paid or volunteer worker, student, or homemaker.
- Family functioning, including interactions with spouse, children, parents, and other relatives.
- Broad social functioning, including roles, activities, and interactions with other individuals and groups in the community at large.

Ratings are to be made for each area of functioning, using a semi-quantitative 6–point scale based on frequency and intensity of impairments, as outlined in the appended Multiaxial Diagnostic Format. The scale anchor point descriptions follow: 0=None: No identifiable disability; 1=Minimal: Low disability in intensity and frequency; 2=Moderate: Medium disability in intensity or frequency, lower in the other; 3=Substantial: Medium disability in intensity and frequency; 4=Severe: High disability in

intensity or frequency, lower in the other; 5=Massive: High disability in intensity and frequency.

7.6 Axis III (Contextual Factors) comprises a list of all relevant psychosocial and environmental problems. Such problems may be relevant to the onset, exacerbation, or maintenance of a disorder listed on Axis I or be in themselves targets of clinical care. They may be acute events or chronic circumstances. This axis also includes personal problems that do not amount to a disorder proper, but are of clinical significance (e.g. accentuated personality, hazardous, violent, abusive, and suicidal behaviors). Contextual factors can be coded according to ICD-10 Z codes (Factors influencing health status and contact with health services) (WHO, 1992).

7.7 Axis IV (Quality of Life) is a multidimensional and global assessment of the patient's self-perceived well being in areas such as physical and emotional status, satisfaction with independent, occupational and interpersonal functioning and with social-emotional and instrumental supports, and a sense of personal and spiritual fulfillment. Its assessment should be culturally-informed. Its appraisal may be based on one of the many standardized quality of life instruments available or a direct global self rating using a scale such as that provided on the appended Multiaxial Diagnostic Format.

7.8 Domains of the multiaxial formulation should be assessed with sensitivity to the culture of the patient. The identification and rating of the importance of significant problems in health, functioning, and social context should be made in relation to pertinent cultural norms and customs.

7.9 The completion of a multiaxial assessment can be enhanced by the availability of a suitable format in the patient's clinical chart. Such a format should ensure that all the domains of the multiaxial schema are attended to and systematically appraised. A prototype of this format is furnished as an appendix.

7.10 The main purpose of the multiaxial diagnostic formulation is to inform the preparation of a comprehensive treatment plan (see section 9). Additionally, it may facilitate and optimize longitudinal reassessments of the patient's condition and therefore afford a refinement of the validity of clinical diagnosis. Furthermore, it can serve as an outcome measure of therapeutic interventions.

References: (Section 7)

World Health Organization (1992). ICD-10 Classification of mental and behavioral disorders: Clinical descriptions and diagnostic guidelines. Geneva: WHO.

World Health Organization (1997). Multiaxial presentation of ICD-10 for use in adult psychiatry. Cambridge, UK: Cambridge University Press.

Recommended Readings

Arbeitskreis, O. P. D. (Hrsg.) (1998): Operationalisierte Psychodynamische Diagnostik (Operationalized Psychodynamic Diagnosis). 2. Auflage. Bern: Huber.

Kastrup, M., Wig, N. N. (1986). The transcultural perspectives of the multiaxial classification. Indian Journal of Social Psychiatry, 2, 289-300.

Mezzich J. E., Janca A., Kastrup M. C. (in press): Multiaxial diagnosis in psychiatry. In: Maj M. et al. (eds): The Future of Psychiatric Diagnosis and Classification. Chichester (UK): John Wiley.

Williams, J. W. B. (1997). The DSM-IV Multiaxial System. In: T. A. Widiger et al (eds): DSM-IV Source Book. Volume, pp. 393-400. Washington D.C.: American Psychiatric Association.

World Health Organization (1996). Multiaxial Classification of Child and Adolescent Psychiatric Disorders. Cambridge, UK: Cambridge University Press.

8. IDIOGRAPHIC PERSONALIZED DIAGNOSTIC FORMULATION

Guidelines

8.1 The diagnostic process involves more than identifying a disorder or distinguishing one disorder from another. It should lead to a thorough, contextualized and interactive understanding of a clinical condition and of the wholeness of the person who presents for evaluation and care.

8.2 This comprehensive concept of diagnosis is implemented through the articulation of two diagnostic levels. The first is a standardized multiaxial diagnostic formulation, which describes the patient's illness and clinical condition through standardized typologies and scales (see Section 7). The second is an idiographic diagnostic formulation, which complements the standardized formulation with a personalized and flexible statement.

8.3 The preparation of the idiographic formulation starts with the recognition of the perspectives of the clinician, the patient, and, whenever appropriate, the family on what is unique, important and meaningful about the patient. The formulation presents an articulation and integration of these perspectives, which could be discrepant from each other, and call for an interactive resolution and joint understanding of the case at hand.

8.4 The clinician's perspectives should represent a synthesizing and integrative effort to identify the essential features of the patient's clinical condition and the biological (e.g. genetic, molecular, toxic), psychological (e.g. psychodynamic, behavioral, cognitive), and social (e. g. supports, cultural) factors that are relevant to such condition.

8.5 The perspectives of the patient and the family should cover their understanding of the clinical condition and its contributory factors, the patient's self-image, assets, and strengths and what is meaningful in life, as well as their expectations for the clinical care process. This information should be elicited through questions placed strategically throughout the clinical interview, such as: What problem brought you here? How do you explain what has happened to you? What is important for you in life? and What do you expect from clinical care? Most important to elicit the patient's and family's perspectives is to listen well. Learning to listen requires didactic instruction, practice, and feedback, as well as knowledge of the patient's cultural background.

8.6 Integration of clinician and patient perspectives, essential for a therapeutic alliance, should be based on empathetic rapport, reflecting mutual respect and interest, and human feeling between clinician and patient. The clinician and patient (with the collaboration of the family as needed) should attempt to reach a joint understanding, to the maximum extent possible, of 1) clinical problems and their contextualization, 2) patient's positive factors, and 3) expectations about restoration and promotion of health. Each of these elements is outlined below. Finally, clinician, patient and family should jointly monitor the progress of care and its outcome and agree on adjustments to be made.

8.7 The first element of the Idiographic Formulation covers Clinical Problems and their Contextualization**.** These include disorders, symptoms, and problems, based on the Standardized Multiaxial Formulation, in language shared by the clinician, the patient, and the family, as well as key complementary information and the elucidation of pertinent mechanisms and contributory factors, from biological, psychological, social and cultural perspectives. Important disagreements should be mentioned and their resolution addressed.

8.8 The second element of the Idiographic Formulation describes the Patient's Positive Factors**.** These include factors that are pertinent to the treatment of the clinical condition and to health promotion, e.g. personality maturity, skills, talents, social resources and supports, and personal and spiritual aspirations.

8.9 The third element of the Idiographic Formulation outlines expectations about Restoration and Promotion of Health. These include specific expectations about the types of treatments and their results as well as aspirations about health status and quality of life in the foreseeable future.

8.10 The Idiographic Formulation should be presented in natural or colloquial language to maximize flexibility. The length of a written Idiographic Formulation could be about one page (see proposed format attached), and that of an oral presentation about five minutes. While this length may be advisable in general, it may vary from a very short statement to a much more extensive one, depending on time available, purposes and format of clinical care, and other circumstances.

Recommended Readings

American Psychiatric Association (1995). Practice guidelines for psychiatric evaluation of adults. The American Journal of Psychiatry, 152 (Suppl.) 67-80.

DeVries M. W. (Ed) (1990). The experience of psychopathology: Investigating mental disorders in their natural settings. Cambridge, UK.: Cambridge University Press.

Kleinman, A. (1988). Rethinking psychiatry: From cultural category to personal experience. New York: Free Press.

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Ross, C. A., Leichner, P. (1986). Canadian and British opinions on formulation. Annals of the Royal College of Physicians & Surgeons of Canada, 19, 49-52.

COMPREHENSIVE DIAGNOSTIC FORMULATION

(WPA International Guidelines for Diagnostic Assessment, IGDA)

Name: _____Record N°: _____Date(d/m/y):_____

Age:_____ Gender: ☐M ☐F Marital Status:_____ Occupation:_____

FIRST COMPONENT: STANDARDIZED MULTIAXIAL FORMULATION

Axis I: Clinical Disorders (as classified in ICD-10).

A. Mental Disorders (mental disorders in general, including personality and development disorders): Codes

B. General Medical Disorders: Codes

Axis II: Disabilities

Areas of Disability		Disability Scale *						
		0	1	2	3	4	5	U
A	Personal Care							
B	Occupational (wage earner, student, etc)							
C	With family							
D	Social in general							

(*) 0= None; 1= Minimal; 2 = Moderate; 3 = Substantial; 4 = Severe; 5 = Massive; U = Unknown; according to the intensity and frequency of disabilities recently present.

Axis III: Contextual Factors (Psychosocial problems pertinent to the presentation, course or treatment of the patient's disorders or relevant to clinical care, as well as personal problems, such as hazardous, violent, abusive, and suicidal behaviors, that do not amount to a standard disorder).

	Problem Areas (Check areas with significant problems and then specify them)	Z Codes
	1. Family/House:	
	2. Education/Work:	
	3. Economic/Legal:	
	4. Cultural/Environmental:	
	5. Personal:	

Axis IV: Quality of Life (To indicate the perceived level of quality of life by the patient, from poor to excellent, mark one of the 10 points on the line below. This level can be determined through an appropriate multidimensional instrument or by direct global rating).

Poor Excellent

0 1 2 3 4 5 6 7 8 9 10

COMPREHENSIVE DIAGNOSTIC FORMULATION

(WPA International Guidelines for Diagnostic Assessment, IGDA)

SECOND COMPONENT: IDIOGRAPHIC FORMULATION

I: Clinical Problems and their Contextualization (Include disorders, symptoms, and problems, based on the Standardized Multiaxial Formulation, in language shared by the clinician, patient and family, as well as complementary key information, mechanisms and explanations from biological, psychological, social, and cultural perspectives)

II: Positive Factors of the Patient (Include resources pertinent to treatment and health promotion, e.g., maturity of personality, abilities, talents and coping skills, social supports and resources, and personal and spiritual aspirations).

III: Expectations on Restoration and Promotion of Health (Include specific expectations on types and outcome of treatment and aspirations on health status and quality of life for the foreseeable future).

9. LINKING DIAGNOSIS TO CARE: TREATMENT PLANNING

Guidelines

9.1 Clinical care starts with the first diagnostic interview. Therapeutic planning and prognosis are to be based on competently conducted and documented comprehensive diagnosis, i.e. a standardized multiaxial formulation covering clinical disorders, disabilities, contextual problems and quality of life, as well as an idiographic or personalized formulation articulating the perspectives of the clinician with those of the patient and family on contextualized clinical problems, patient's positive factors, and expectations about restoration and promotion of health.

9.2 The treatment or care plan involves a listing of clinical problems as targets for treatment and the formulation of a program of care for each one of them.

9.3 The basic elements for constructing a list of clinical problems come from the set of clinical disorders, disabilities and contextual factors presented in the multiaxial diagnostic formulation as well as from considerations presented in the idiographic formulation. A problem should be delineated as to be the target of a cohesive program of care. The list of problems should be kept reasonably simple and short in order not to duplicate treatment programs unnecessarily or to burden the clinicians with excessive documentation requirements.

9.4 The program of care planned for each identified problem may include biological (e.g., pharmacological, ECT), psychological (e.g., psychodynamic, cognitive-behavioral), and social (e.g., family and group therapies, educational and vocational rehabilitation, housing assistance) therapies as well as additional diagnostic studies (e.g., imaging, I.Q. testing, cultural consultation). Every planned intervention should be specifically and clearly described.

9.5 Although disorder-based treatment algorithms and practice guidelines may be helpful as references, actual programs of care should be personalized, giving attention to illness complexity (e.g., comorbidity, pattern of disabilities and contextual factors), range of patient's assets, and local treatment resources and health care norms.

9.6 All elements of the care plan (listing of clinical problems and specific interventions) should be worked out collaboratively between the clinician and the patient and available family members. Pointed efforts should be made towards joint expectations on treatment goals and shared awareness of the likely benefits and side effects of selected therapies.

9.7 As multidisciplinary teams are usually required for effective health care, it is crucial that all key members of the team participate in the design of the treatment plan. This plan should facilitate professional communication among all team members working with a particular patient and promote fully coordinated therapeutic efforts.

9.8 Prognosis should also be based on a comprehensive diagnostic formulation rather than just on a single disorder. Psychopathological, substance abuse, and personality comorbities, concomitant general medical conditions, occupational and interpersonal disabilities, available social supports and therapeutic resources as well as idiographic perspectives on contextualized clinical problems, patient's assets and expectations are all relevant to the prediction of illness course and therapeutic outcome. Outcome itself is a pluralistic concept as it involves symptomatological remission, functional improvement, activation of supports and enhancement of quality of life.

9.9 Clinician-patient engagement and partnership is as important for care planning as it is for diagnostic formulation. Such engagement involves awareness of the cultural framework of both the experience of illness and the process of seeking and providing help. Clinical care includes not only curative efforts but also empathic consolation and promotion of healthy behaviors and quality of life. Engaging the patient is critical for the attainment of therapeutic effectiveness and the fulfillment of ethical responsibilities.

9.10 The linking of comprehensive diagnosis to comprehensive treatment can be facilitated by the use of a treatment plan format. Such a format should be completed jointly by all members of the clinical team working with the patient, who should also be involved in this process. A prototype treatment plan format, which articulates the listing of clinical problems with specific interventions and allows space for special observations, is appended.

Recommended Readings

Cournos, F., Cabaniss, D. L. (2000). Clinical evaluation and treatment planning: a multimodal approach. In: A. Tasman, S. Kay & J. A. Lieberman (eds). Psychiatry. pp. 477-497. Philadelphia: Saunders.

Harding, C. M. (1998). Reassessing a person with schizophrenia and developing a new treatment plan. In: J. W. Barron (ed): Making diagnosis meaningful. pp. 319-338. Washington, D. C.: American Psychological Association.

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Mirin, S. M., Namerow, M. J. (1991). Why study treatment outcome? In: S. M. Mirin, J. T. Gossett & M. C. Grob (Eds.). Psychiatric treatment: Advances in outcome research. Washington, D. C.: American Psychiatric Press.

TREATMENT PLAN FORMAT

Name: _____Record N°: _____Date(d/m/y):_____

Age:_____ Gender: ☐M ☐F Marital Status:_____ Occupation:_____

Clinicians involved:_____

Setting:_____

Instructions:
Under **Clinical Problems** list as targets for care key clinical disorders, disabilities, and contextual problems presented in the multiaxial diagnostic formulation, as well as problems noted in the idiographic formulation. After the problem name, consider listing its key descriptors. Keep the list as simple and short as possible. Consolidate into one encompassing term all those problems that share the same intervention.
Interventions should list diagnostic studies as well as treatment and health promotion activities pertinent to each clinical problem. Be as specific as possible in identifying modalities planned, doses and schedules, amounts and time frames, as well as the corresponding responsible clinicians.
The space for **Observations** may be used in a flexible way as needed. Illustratively, it could include target dates for problem resolution, dates of scheduled reassessments, and notes that a problem has been resolved or has become inactive.

Clinical Problems	Interventions	Observations

10. ORGANIZING THE CLINICAL CHART

Guidelines

10.1 A systematic record of information collected during the process of diagnosis and care is essential to document understanding of the patient's mental, physical and social condition and clinical service provided.

10.2 Clinical charts are basic informational tools for all members of the clinical team. They should be kept in a secure and confidential location and shall be accessible through an orderly process to authorized clinical personnel. In some settings, clinical charts may be electronically available.

10.3 A chart should include narrative statements (using patient's own words whenever possible) in all sections of the assessment and care process. An effort should be made to ensure legibility of these statements. Occasionally, a chart may include, in its relevant sections, structured or semi-structured components to ensure that important information is covered in an effective way.

10.4 The clinical chart should begin with a record of basic identifying information, including the patient's name, address, telephone number, date of birth, sex, ethnicity, religion, education, marital status, employment status, insurance coverage (if relevant), and next of kin.

10.5 The results of a clinical diagnostic assessment and its linkage to care should be recorded in narrative form under standard headings, such as the following:

- Sources of information
- Chief complaint/reason for evaluation
- History of present illness
- Past psychiatric and general medical history
- Family history
- Personal, developmental, and social history
- Symptom and mental status evaluation
- Physical examination
- Supplementary assessments
- Comprehensive diagnostic formulation
- Comprehensive treatment plan

10.6 The history of psychiatric and general medical illnesses should be recorded, as much as possible, in chronological sequence with important milestones, ages, dates, and events noted.

10.7 Family history of mental and general medical disorders and treatment should be collected for all known first- and second-degree relatives, including children, on both sides of the family. Personal, developmental and social history should be recorded chronologically.

In addiction to narrative statements, key milestones and critical events may be recorded in a structural manner.

10.8 The record of the symptom and mental status examination should cover all important areas of mentation and behavior (e.g. appearance, overt behavior, mood and affect, speech and thought process, thought content, perception, sensorium, memory, judgement and insight.) In every case, personalized descriptions should be presented. Accessorily, checklists may be used. Whenever possible, a physical examination should also be conducted.

10.9 A comprehensive diagnostic formulation that organizes critical information obtained through standardized and idiographic formulations should be recorded. The use of a systematic format, such as the one presented in Section 8, is advisable.

10.10 The clinical chart should include a comprehensive treatment plan, the preparation of which is based on the comprehensive diagnostic formulation. It is advisable to use a systematic treatment plan format articulating clinical problems to specific interventions, such as the one presented in Section 9.

Recommended Readings

Mezzich, J. E. (ed) (1986). Clinical Care and Information Systems in Psychiatry. Washington D. C.: American Psychiatric Press.

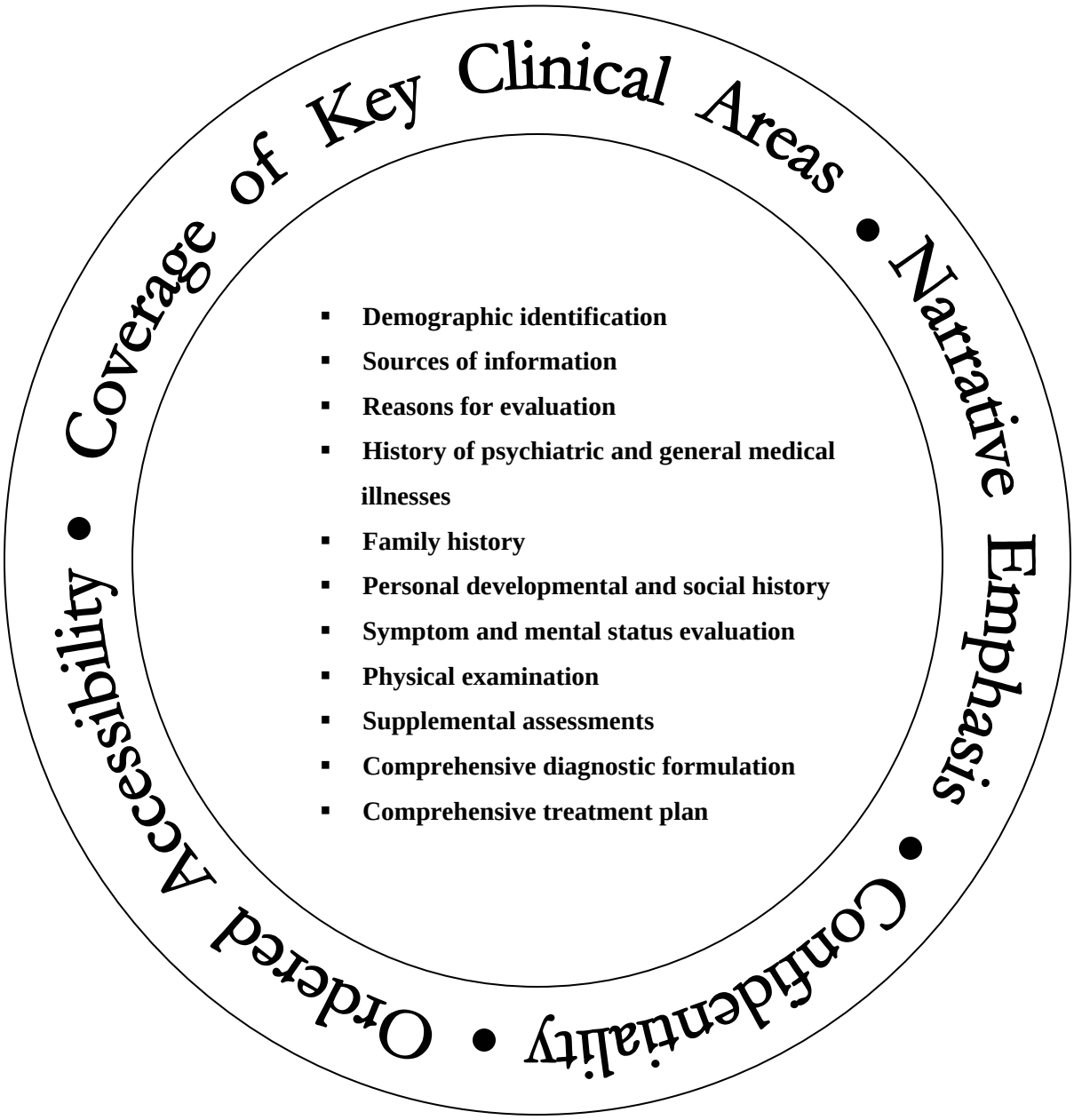
Sadock, B.J. (2000). Psychiatric report and medical record. In: B. J. Sadock & V. A. Sadock (Eds). Kaplan & Sadock's Comprehensive Textbook of Psychiatry, 7th Edition. pp. 665-677. Philadelphia: Lippincott, Williams & Wilkins.

Sims, H. (2000). Clinical evaluation in psychiatry. In: F. Henn et al. (Eds). Contemporary Psychiatry, Vol. I. Berlin: Springer.

Soreff, S., Gulkin, T., Pike, J. G. (1990). The evolving clinical chart: How it reflects and influences psychiatric and medical practice and the quality of care. Psychiatric Clinics of North America, 13, 127-133.

Vidal, G., Alarcón, R. D. (1986). Psiquiatría (Psychiatry). Buenos Aires: Panamericana.

Figure 5: Organizing a Clinical Chart (Section 10)



APPENDIX

Illustrative Clinical Case

Demographic Identification, Sources of Information and Reasons for Evaluation

Ms. Y is a 28 year-old monolingual Spanish-speaking woman of Mexican origin living for two years in the United States and married to a Mexican man self-employed in the construction business. She presents for care to the emergency room accompanied by a female friend complaining of "nervios", feeling guilty for not being able to perform her duties as a wife, and concerned that there may be some type of imbalance in her body. The interviewer is a female psychiatrist, born in South America and trained in the United States.

History of Psychiatric and General Medical Illnesses

Ms. Y reports that she has been having "nervios" for the past few months. She describes this condition as feeling desperate, "like having a knot in my throat". Upon further questioning, she acknowledges feeling sad for the past 6 months. She attributes her sadness to feelings of loneliness. Additionally, she acknowledges frequent crying, usually in relation to her remembering her family in Mexico. She has been experiencing insomnia and decreased appetite with a 10-pound weight loss. Her energy has decreased, as she has to make an extra effort to complete her daily routine, which includes doing all the house chores. She verbalizes some anger towards her husband for expecting her to have a full meal prepared by the time he gets home. At the same time, she is proud to explain that she makes her own *masa* for her *tortillas*. She denies having had homicidal or suicidal thoughts. She has also complained of headaches, occasional palpitations and generalized muscle aches for the last two weeks. These symptoms occur throughout the day and are usually relieved by rest and non-prescription non-steroidal anti-inflammatory agents. She denies having had any manifestations of psychotic disturbances, alcohol or drug use. She has been on birth control medication for 2 years.

Family, Developmental and Social History

Ms. Y was born in a small town in Mexico. She was the oldest and only female in a sibship of three. Her father left the family when she was six years old and her mother took them to live with grandparents. She has not had any contact with her father since then. Her siblings and mother still live in Mexico. She reports good memories from her childhood and that her grandparents were very supportive.

She grew up in a low middle-class neighborhood and was raised as a Catholic attending church every Sunday with her family. Her mother had to work very hard in order to support all the children and therefore she was often absent from home. However, she was devoted to spending all available time with the kids.

Ms. Y completed high school and then went to work as a secretary for a large company in town. She assumed increasing responsibilities within the company and achieved the position of supervisor for a whole floor. She stayed with the company for a total of six years.

Ms. Y met her husband through her job while he was doing business with her company. They dated for two years and finally decided to get married when the company went bankrupt after the devaluation of the Mexican peso in 1994. Her family supported her wedding decision and then the couple moved to the US.

Ms. Y lives with her husband in a house they rent. Her husband is self-employed and works in the construction business. She describes her husband as hardworking and very "traditional" in his views of marriage and denies any type of abuse from him. She states that she is happy with her marriage although recognizes that they have some problems. She feels that marriage is forever and she needs to work on making it better. She is taking oral contraceptives but has been discussing with her husband the possibility of having children. They are currently saving all the money they can to be able to buy a house.

Ms. Y has been working as a maid for a family for the past year and she enjoys her job, stating that her employer is very supportive and encourages her to learn English. However, she has been unable to attend any classes "because of lack of time". She keeps contact with her family in Mexico, but has not made them aware of her job situation because she is concerned that they would be upset if they knew that she is working as a maid. She misses her family, particularly because they were very close to each other, and remembers fondly getting together every Sunday.

Her current social relations are limited (restricted to the friend who accompanied her to the emergency room) due to her inability to drive. She does not have a driver's license because her permit to stay in the US has expired and she is afraid of getting caught by the Immigration Service. Her husband is a legal resident in the US and she wants him to volunteer to take the steps to make her stay legal. He has not offered to do this so far and she has not explicitly requested this because she doesn't want him to think that all she wants is a "green card". They do not have health insurance coverage.

Symptoms and Mental Status Evaluation

Ms. Y is a young looking and attractive Mexican woman who wears a long and simple dress. She has no make-up on and her hair is combed in a ponytail. She is pleasant in her interactions, initially quite inhibited but slightly more talkative as the interview progresses.

Her speech is spontaneous and somewhat slow. Her thought processes are coherent, logical and goal-directed. There is no evidence of hallucinations, delusions, flight-of-ideas or loose-associations.

Her mood is moderately depressed and she expresses multiple worries. She does not voice any homicidal or suicidal ideation. She moves her hands nervously.

She is alert and oriented to place and time. Her concentration and memory are somewhat impaired. Her intellectual functioning is on the average range as suggested by the vocabulary she utilizes. Her judgment and insight on having clinical problems are good.

Physical Examination

The results of this examination appear to be within normal limits, except that the patient looks pale, and her skin is cold and dry.

Supplementary Assessments

Her cell blood count (CBC) shows mild microcytic anemia. Iron studies show that serum ferritin is decreased, the iron-binding capacity of the serum (TIBC) is increased, and total iron is decreased. Thyroid-Stimulating Hormone (TSH) is mildly elevated.

COMPREHENSIVE DIAGNOSTIC FORMULATION

(WPA International Guidelines for Diagnostic Assessment, IGDA)

Name: *Ms. Y* Record N°: *V001* Date(d/m/y): *March 19, 2001*

Age: *28* Gender: M XF Marital Status: *Married* Occupation: *Domestic Worker*

FIRST COMPONENT: STANDARDIZED MULTIAXIAL FORMULATION

Axis I: Clinical Disorders (as classified in ICD-10).

A. Mental Disorders (mental disorders in general, including personality and development disorders):

	Codes
Moderate Depressive Episode	*F 32.1*

B. General Medical Disorders:

	Codes
Iron-deficiency Anemia	*D50.9*
Hypothyroidism	*E03.9*

Axis II: Disabilities

	Areas of Disability	Disability Scale *						
		0	1	2	3	4	5	U
A	Personal Care		x					
B	Occupational (wage earner, student, etc)				x			
C	With family				x			
D	Social in general				x			

(*) 0= None; 1= Minimal; 2 = Moderate; 3 = Substantial; 4 = Severe; 5 = Massive; U = Unknown; according to the intensity and frequency of disabilities recently present.

Axis III: Contextual Factors (Psychosocial problems pertinent to the presentation, course or treatment of the patient's disorders or relevant to clinical care, as well as personal problems, such as hazardous, violent, abusive, and suicidal behaviors, that do not amount to a standard disorder).

	Problem Areas (check areas with significant problems and then specify them)	Z Codes
X	1. Family/House: *Marital conflict, separation from family of origin*	*Z63*
X	2. Education/Work: *Language limitations, underemployment*	*Z56, Z60.3*
X	3. Economic/Legal: *Not a legal resident, no health insurance*	*Z65.3, Z59.7*
X	4. Cultural/Environmental: *Gender role and cultural adaptation conflicts*	*Z60.8*
	5. Personal:	

Axis IV: Quality of Life (To indicate the perceived level of quality of life by the patient, from poor to excellent, mark one of the 10 points on the line below. This level can be determined through an appropriate multidimensional instrument or by direct global rating).

Poor Excellent

x

0 1 2 3 4 5 6 7 8 9 10

COMPREHENSIVE DIAGNOSTIC FORMULATION
(WPA International Guidelines for Diagnostic Assessment, IGDA)

SECOND COMPONENT: IDIOGRAPHIC FORMULATION

I: Clinical Problems and their Contextualization (Include disorders, symptoms, and problems, based on the Standardized Multiaxial Formulation, in language shared by the clinician, patient and family, as well as complementary key information, mechanisms and explanations from biological, psychological, social, and cultural perspectives)

Patient consults for "nervios", feeling "desperate", experiencing symptoms of clinical depression (sadness, insomnia, anxiety, appetite and weight loss, decreased energy, concentration and memory, palpitations, headaches, and generalized muscle aches) associated with substantial impairment in social functioning. Clinician and patient agree that this condition is related in part to her social history and situation (isolation derived from separation from family of origin, language barriers and transportation limitations, lack of legal residence, of security, and of health insurance, underemployment, marital difficulties, and cultural conflicts). Anemia and hypothyroidism are additionally noted as problems, which may contribute to her depressive condition.

II: Positive Factors of the Patient (Include resources pertinent to treatment and health promotion, e.g., maturity of personality, abilities, talents and coping skills, social supports and resources, and personal and spiritual aspirations).

Patient completed high school education and had supervisory office experience. She has no previous history of mental illness nor of alcohol or drug use. She feels identified with her cultural roots and at the same time appears motivated to do well in the host society. She currently holds a job and her employer is quite supportive. She has a friend that provides transportation. She is articulate and motivated to get better.

III: Expectations on Restoration and Promotion of Health (Include specific expectations on types and outcome of treatment and aspirations on health status and quality of life for the foreseeable future).

Clinician and patient agree that the present depressive condition is quite treatable with both medication and psychotherapy. They further agree that attention to her situation of isolation, problematic legal situation, and marital conflicts is likely to both ameliorate her depression and improve her quality of life. They also agree that her anemia and hypothyroidism are treatable with medication. Health promotion strategies may also include attention to nutritional habits, as well as affirmation of her cultural identity and of her competencies, talents and social supports.

TREATMENT PLAN FORMAT

Name: *Ms. Y* Record N°: *V001* Date(d/m/y): *March 19, 2001*

Age: *28* Gender: _M x F Marital Status: *Married* Occupation: *Domestic Worker*

Clinicians involved: *Psychiatrist and, prospectively, a primary care physician and a social worker*

Setting: *Outpatient Clinic*

Instructions:
Under **Clinical Problems** list as targets for care key clinical disorders, disabilities, and contextual problems presented in the multiaxial diagnostic formulation, as well as problems noted in the idiographic formulation. After the problem name, consider listing its key descriptors. Keep the list as simple and short as possible. Consolidate into one encompassing term all those problems that share the same intervention.
Interventions should list diagnostic studies as well as treatment and health promotion activities pertinent to each clinical problem. Be as specific as possible in identifying modalities planned, doses and schedules, amounts and time frames, as well as the corresponding responsible clinicians.
The space for **Observations** may be used in a flexible way as needed. Illustratively, it could include target dates for problem resolution, dates of scheduled reassessments, and notes that a problem has been resolved or has become inactive.

Clinical Problems	Interventions	Observations
1. Depression *(sadness, insomnia, weight loss)*	*a. Start SSRI antidepressant, adjusting dose according to response and side-effects* *b. Psychotherapy with Spanish-speaking female therapist, engaging husband as therapy progresses, and considering health promotion strategies focused on strengthening patient's positive factors*	*Reevaluate in 2 weeks* *Reassess in 8 weeks*
2. Socio-cultural problems *(marital, gender and cultural conflicts)*	*a. Prepare Cultural Formulation to clarify cultural identity and relations to illness and care* *b. Referral to Social Services for immigration, isolation, and other social problems*	*Reassess in 8 weeks*
3. Iron-deficient anemia	*a. Prescription of iron 325 mg tid* *b. Referral to Primary Care service (PC)*	*Follow-up on PC referral*
4. Hypothyroidism	*a. Levothyroxine .025 mg/d* *b. Referral to Primary Care Service (PC)*	*Follow-up on PC referral*