

Discussion 3

Prior to beginning work on this discussion, please read Chapters 8, 12, and 13 in *DSM 5 Made Easy: The Clinician's Guide to Diagnosis*; Chapter 2 in *Turning Points in Dynamic Psychotherapy: Initial Assessment, Boundaries, Money, Disruptions and Suicidal Crises*; Chapter 5 in *The Psychiatric Interview: Evaluation and Diagnosis*; all required articles; and review the [PSY645 Fictional Sociocultural Case Studies](#) (Links to an external site.) document.

One of the most important aspects of developing competence in psychopathology is to be as honestly and completely aware as possible of your personal attitudes toward people who have mental health conditions. Through this awareness, we are better able to challenge our own biases and prejudicial views in order to be more open to the findings within scholarly research.

For your initial post in this discussion, choose one of the three case studies from the [PSY645 Fictional Sociocultural Case Studies](#) (Links to an external site.) document, and write a detailed description of your uncensored personal observation of the patient depicted. Describe at least one theoretical orientation you would use to conceptualize your view of the patient's problem and how it may have developed. Identify the issues you might focus on in treatment with this patient. Be sure to identify within your post which of the three case studies you have chosen.

PSY645 Fictional Sociocultural Case Studies

Case #1

Frank is a 45-year-old male who identifies as gay. He stated his reason for seeking out psychotherapy “is because my boyfriend doesn’t want to have sex with me.” When asked about the frequency of his sexual activity with his boyfriend, he reported that they have sex at least once a week. While this tends to be the average amount of sex that couples generally have, he repeated, “You don’t understand. I just want him to have sex with me!” When asked to share his boyfriend’s name, Frank responded, “Orlando Bloom... you know, the actor in those movies.” Frank appeared well groomed with logical thought and poor insight into his problems. He denied symptoms of depression and anxiety.

Case #2

Chrissy is a 28-year-old female of Argentinean descent. Chrissy was born in the United States two years after her parents emigrated. She stated her reason for seeking out psychotherapy “is because my family won’t let me be the person I want to be.” She endorses symptoms of depression and chronic passive suicidal ideation with a plan but no intent. One of her goals in life is to be an independent entrepreneur, as she wants to start a designer clothing line for pregnant women. However, this goes against her family’s expectation that she become a stay at home mom and raise children of her own. She appeared well groomed with logical thought and moderate insight into her problems.

Case #3

Harvey and Tina are a middle-aged mixed-race couple who present for counseling after 20 years of marriage. They state that there are no known problems in their marriage, but they would like to establish a safe space to discuss issues as they might develop. While gathering history, you learn that Tina was born as Anthony and went through sex reassignment surgery two years into her relationship with Harvey. Shortly after going through sex reassignment, Harvey and Tina married. Harvey and Tina appeared well groomed with superior insight and no plans to use insurance for counseling.

CHAPTER 6

Somatic Symptom and Related Disorders

Quick Guide to the Somatic Symptom and Related Disorders

When somatic (body) symptoms are a prominent reason for evaluation by a clinician, the diagnosis will often be one of the disorders (or categories) listed below. As usual, the link indicates where a more detailed discussion begins.

Primary Somatic Symptom Disorders

Somatic symptom disorder. Formerly called somatization disorder, this chronic condition is characterized by unexplained physical symptoms. It is found almost exclusively in women.

Somatic symptom disorder, with predominant pain. The pain in question has no apparent physical or physiological basis, or it far exceeds the usual expectations, given the patient's actual physical condition.

Conversion disorder (functional neurological symptom disorder). These patients complain of isolated symptoms that seem to have no physical cause.

Illness anxiety disorder. Formerly called hypochondriasis, this is a disorder in which physically healthy people have an unfounded fear of a serious, often life-threatening illness such as cancer or heart disease—but little in the way of somatic symptoms.

Psychological factors affecting other medical conditions. A patient's mental or emotional issues influence the course or care of a medical disorder.

Factitious disorder imposed on self. Patients who want to occupy the sick role (perhaps they enjoy the attention of being in a hospital) consciously fabricate symptoms to attract attention from health care professionals.

Factitious disorder imposed on another. A person induces symptoms in someone else, often a child, possibly for the purpose of gaining attention.

Other specified, or unspecified, somatic symptom and related disorder. These are catch-all categories for patients whose somatic symptoms fail to meet criteria for any better-defined disorder.

Other Causes of Somatic Complaints

Actual physical illness. Psychological causes for physical symptoms should be considered only after physical disorders have been eliminated.

Mood disorders. Pain with no apparent physical cause is characteristic of some patients with major depressive disorder and bipolar I disorder, current or most recent episode depressed. Because they are treatable and potentially life-threatening, these possibilities must be investigated early.

Substance use. Patients who use substances may complain of pain or other physical symptoms. These may result from the effects of substance intoxication or withdrawal.

Adjustment disorder. Some patients who are experiencing a reaction to environmental circumstances will complain of pain or other somatic symptoms.

Malingering. These patients know that their somatic (or psychological) symptoms are fabricated, and their motive is some form of material gain, such as avoiding punishment or work, or obtaining money or drugs.

INTRODUCTION

For centuries, clinicians have recognized that physical symptoms and concerns about health can have emotional origins. DSM-III and its successors have gathered several alternatives to organic diagnoses under one umbrella. Collectively, these are now called the somatic symptom and related disorders, because their presentations resemble somatic (bodily) disease. Like so many other groups of disorders discussed in this book, these conditions are not bound together by common etiologies, family histories, treatments, or other factors. This chapter is simply another convenient collection—in this case, of conditions that are concerned primarily with physical symptoms.

Several sorts of problems can suggest somatic symptom disorder. These include the following:

- Pain that is excessive or chronic
- Conversion symptoms (see sidebar below)
- Chronic, multiple symptoms that seem to lack an adequate explanation
- Complaints that don't improve, despite treatment that helps most patients
- Excessive concern with health or body appearance

Patients with somatic symptom and related disorders have usually been evaluated (perhaps many times) for physical illness. These evaluations often lead to testing and treatments that are expensive, time-consuming, ineffective, and sometimes dangerous. The result of such treatment may be only to reinforce the patients' fearful belief in some nonexistent medical illness. At some point, health care personnel recognize that whatever is wrong has strong emotional underpinnings, and refer these patients for mental health evaluation.

It is important to acknowledge that, with the obvious exception of factitious disorder, these patients are not faking their symptoms. Rather, they often believe that they have something seriously wrong; this belief can cause them enormous anxiety and impairment. Without meaning to, they inflict great suffering on themselves and on those around them.

On the other hand, we must also remember that the mere presence of a somatic symptom disorder does not ensure against the subsequent development of another medical condition. These patients can also develop other forms of mental disturbance.

F45.1 [300.82] Somatic Symptom Disorder

The DSM-5 criteria for somatic symptom disorder (SSD) require only a single somatic symptom, but it must cause distress or markedly impair the patient's functioning. Nonetheless, the classical patient has a pattern of multiple physical and emotional symptoms that can affect various (often many) areas of the body, including pain symptoms, problems with breathing or heartbeat, abdominal complaints, and/or menstrual disorders. Of course, conversion symptoms (body dysfunctioning such as paralysis or blindness that has no anatomical or physiological cause) may also be encountered. Treatment that usually helps symptoms that are caused by actual physical disease is usually ineffective in the long run for these patients.

SSD* begins early in life, usually in the teens or early 20s, and can last for many years—perhaps the patient's entire lifetime. Often overlooked by health care professionals, this condition affects about 1% of all women; it occurs less often in men, though the actual ratio is unknown, considering that the definition of SSD has only just been written. SSD may account for 7–8% of mental health clinic patients and perhaps nearly that percentage of hospitalized mental health patients. It has a strong tendency to run in families. Transmission is probably both genetic and environmental; SSD may be more frequent in patients with low socioeconomic status and less education.

Half or more of patients with SSD have anxiety and mood symptoms. There is an ever-present danger that clinicians will diagnose an anxiety or mood disorder and ignore the underlying SSD. Then

the all-too-common result is that the patient receives treatment specific for the mood or anxiety disorder, rather than an approach that might actually address the underlying SSD.

Essential Features of Somatic Symptom Disorder

Concern about one or more somatic symptoms leads the patient to express a high level of health anxiety by investing excessive time in health care or being excessively worried as to the seriousness of symptoms.

The Fine Print

The D's: • Duration (6+ months) • Differential diagnosis (DSM-5 does not state one; I would cite substance use and physical disorders, mood or anxiety disorders, psychotic or stress disorders, dissociative disorders)

Coding Notes

Specify if:

With predominant pain. For patients who complain mainly of pain. See the additional discussion on page 257.

Persistent. If the course is marked by serious symptoms, lots of impairment, and a duration greater than 6 months.

Consider the following behaviors related to seriousness of patient's symptoms: excessive thoughts, persistent high anxiety, excessive energy/time expended. Now rate severity:

Mild. One of these behaviors.

Moderate, 2+.

Severe. 2+, along with numerous somatic complaints (or one extremely severe complaint).

In my own professional lifetime, this mental disorder has borne four different names. *Hysteria* was created over 2,000 years ago by the Greeks, who famously believed that its symptoms arose from a uterus that wandered throughout the body, producing pain or stopping the breath or clogging the throat. That ancient term remained in use until the middle of the 20th century, when it received a new label and a more complicated definition.

Briquet syndrome was coined to honor the 19th-century French physician who first described the disorder's typical polysymptomatic presentation. For diagnosis, it required 25 symptoms (of a possible 60), each of which the clinician had to determine to be unsubstantiated by physical or laboratory examination. The list included pseudoneurological symptoms (such as temporary blindness and aphonia), but also emotional symptoms such as depression, anxiety attacks, and hallucinations—plus a lot more.

Twenty-five symptoms were just too many for some clinicians. In 1980, the authors of DSM-III devised the term *somatization disorder* to highlight new criteria that reduced the number of symptoms, along the way discarding all the mental and emotional symptoms from the Briquet symptoms list. DSM-III-R and DSM-IV further redefined and shortened the list ("dumbed it down," some would say). The Briquet symptoms yielded excellent results in terms of isolating a group of patients who later did *not* turn out to have actual physical disease and who responded well to psychological and behavioral treatment. Even with the simpler somatization disorder symptoms, however, few patients were ever diagnosed; perhaps clinicians didn't want to take the trouble, or perhaps the symptoms were simply too restrictive for practical purposes.

Now, with SSD, we are back where we started: A single symptom, attended by a certain degree of concern on the part of the patient, will suffice for a DSM-5 diagnosis. It is noteworthy that as the names have progressively lengthened, the criteria sets have been getting shorter—with the obvious exception of hysteria itself, which was a seat-of-the-pants diagnosis that entailed identifying but a single symptom, often of the pseudoneurological “conversion” type. It remains to be seen how well the DSM-5 criteria for SSD will discriminate these patients from those with other diagnoses in the somatic symptoms and related disorders group, and from patients with physical illness. But I fear that we really may have truly come full circle, to the point where we are once again in danger of misidentifying people whose symptoms are perplexing, even mysterious, but which may well presage ultimate physical disease.

There's one other issue that deserves our scrutiny: Nowhere do the DSM-5 criteria require that other causes of the patient's symptoms be ruled out. That places the SSD criteria in select company (intellectual disability, personality disorders, substance use disorders, anorexia nervosa, and the paraphilic disorders) as requiring no consideration of a differential diagnosis.

Here's the bottom line. I can indeed make this part of DSM-5 *truly* easy: Other than for the pain specifier, don't use it! Until the data are in that persuade me SSD is a useful concept that promotes the wellbeing of my patients, I will personally continue to use either the old DSM-IV somatization disorder guidelines (see the next sidebar) or the even older Briquet syndrome criteria. And here's my guarantee: Any patient diagnosed by either of these standards will also qualify for a diagnosis of DSM-5 SSD.

Cynthia Fowler

When Cynthia Fowler told her story, she cried. At age 35, she was talking with the most recent in her series of health care professionals. Her history was a complicated one; it began in her mid-teens with arthritis that seemed to move from one joint to another. She had been told that these were "growing pains," but the symptoms had continued to come and go over the intervening 20 years. Although she was subsequently diagnosed as having various types of arthritis, laboratory tests never substantiated any of them. A long succession of treatments had proven fruitless.

In her mid-20s, Cynthia was evaluated for left flank pain, but again nothing was found. Later, abdominal pain and vomiting spells were worked up with gastroscopy and barium X-rays. Each of these studies was normal. A histamine antagonist was added to her growing list of medications, which by now included various anti-inflammatory agents, as well as prescription and over-the-counter analgesics.

Cynthia had thought at one time that many of her symptoms were aggravated by her premenstrual syndrome, which she had recognized in herself after reading about it in a women's magazine. She had invariably been irritable with cramps before her period, which used to be so heavy that she would sometimes stay in bed for several days. When she was 26, therefore, she'd had a total hysterectomy. Six months later, persistent vomiting led to endoscopy; other than adhesions, no abnormalities were found. Alternating diarrhea and constipation then caused her to experiment with a series of preparations to regulate her bowel movements.

When she was questioned about sex, Cynthia shifted uncomfortably in her chair. She didn't care much for it and had never experienced a climax. Her lack of interest was no problem to her, though each of her three husbands had complained a lot. When she was a young teenager, something sexual might have happened to her, she finally admitted, but that was a part of her life she really couldn't recall. "It's as if someone cut a whole year out of my diary," she explained.

When she was 2 and her brother was 6 months old, Cynthia's father had deserted the family. Her mother subsequently worked as a waitress and lived with a succession of men, some of whom she married. When Cynthia was 12, her mother escaped from one of Cynthia's stepfathers; she then placed the two children in foster care.

One way or another, each of Cynthia's former clinicians had disappointed her. "None of the others knew how to help me. But I just know you'll find out what's wrong. Everyone says you're the best in town." Through her tears, she managed a confident smile.

Evaluation of Cynthia Fowler

At a glance, we can affirm that Cynthia had distressing somatic symptoms (criterion A) that for years (C) had occupied a great deal of time and effort (B). That, in essence, earns her a DSM-5 diagnosis of SSD. However, I'd prefer to analyze her condition in light of the old DSM-IV somatization disorder guidelines (see the next sidebar).

Cynthia needed to have at least eight symptoms across the four symptom areas, and she did: pain (abdominal, flank, joint, and menstrual); gastrointestinal (diarrhea, vomiting); sexual (excessive menstrual bleeding, sexual indifference); and a lone pseudoneurological symptom (amnesia). The DSM-IV criteria require that these symptoms not be explainable on the basis of physical disease, and that they impair the patient's functioning in some way—I don't think I'll get much disagreement there, either. They started well before she turned 30, and there is nothing to suggest that she was intentionally feigning them. Q.E.D.

Even so, as with nearly every mental disorder, **another medical condition** is the first possibility that I would seek to rule out. Among the medical and neurological disorders to consider are multiple

sclerosis, spinal cord tumors, and diseases of the heart and lungs. Cynthia had already been worked up for a variety of medical conditions and had been prescribed multiple medications, none of which had done her much good. Judging by the last paragraph of the vignette, her previous clinicians might have been at a loss to diagnose or treat her effectively.

Setting Cynthia's experience apart from patients with actual physical disease are (1) the number and variety of the symptoms (though neither is required by SSD criterion A); (2) the absence of an adequate explanation for the symptoms based on history, lab findings, or physical examination; and (3) inadequate relief from treatments that are ordinarily helpful for the symptoms in question. Note once again that although the SSD criteria allow a diagnosis based on far fewer symptoms than Cynthia had, her history is typical of a group of patients whom clinicians have been attempting to help for millennia.

Certain other somatic symptom and related disorders require discussion. In **SSD with predominant pain**, the patient focuses on severe, sometimes incapacitating somatic pain. Although Cynthia complained of pain in a variety of locations, it was only one aspect of a much broader picture of somatic illness. Patients with **illness anxiety disorder** (formerly hypochondriasis) can have multiple physical symptoms, but their concern focuses on the fear of having a specific physical disease, not, as with Cynthia, particular symptoms. Cynthia did not have any classical physical conversion symptoms (e.g., stocking or glove anesthesia, hemiparalysis), but many patients with SSD do. Then **conversion disorder (functional neurological symptom disorder)** enters the differential diagnosis. However, as with SSD with predominant pain, conversion disorder should not be diagnosed in any patient who fulfills criteria for the more encompassing SSD. In addition, Cynthia's amnesia might qualify for the diagnosis of **dissociative amnesia** if it were the predominant problem.

You should always inquire carefully about **substance-related disorders**, which are found in one-quarter or more of patients with SSD. And when patients come to the attention of mental health providers, it is often because of a concomitant mood disorder or anxiety disorder.

Many patients with SSD also have one or more **personality disorders**. Especially prevalent is **histrionic personality disorder**, though **borderline** and **antisocial** personality disorders may also be diagnosed. Cynthia's words to the clinician in the last paragraph suggest a personality disorder, but with insufficient information, I'd defer that diagnosis for now. There's no way to code it out, so I would mention "possible personality disorder," or some such verbiage, in my summary.

With a GAF score of 61, Cynthia's current diagnosis would read as follows:

F45.1 [300.82] Somatic symptom disorder

Here's an outline of the DSM-IV somatization disorder (SD):

- From an early age, these patients have numerous physical complaints that wax and wane, with new ones often beginning as old ones resolve. With treatment typically ineffective, patients tend to switch health care providers in search of cure.
- The wide variety of possible symptoms fall into several groups.
 - Pain (several different sites are required): in the head, back, chest, abdomen, joints, arms or legs, or genitals; or related to body functions, such as urination, menstruation, or sexual intercourse
 - Gastrointestinal (other than pain): bloating, constipation, diarrhea, nausea, vomiting spells (except during pregnancy), or intolerance of several foods (nominally, three or more)
 - Sexual or reproductive systems (other than pain): difficulty with erection or ejaculation, irregular menses, excessive menstrual flow, or vomiting that persists throughout pregnancy
 - Pseudoneurological (not pain): blindness, deafness, double vision, lump in throat or trouble swallowing, inability to speak, poor balance or coordination, weak or paralyzed muscles, retention of urine, hallucinations, numbness to touch or pain, seizures, amnesia (or any other dissociative symptom), or loss of consciousness (other than fainting)
- The typical patient will have eight or more symptoms, with four (or more) from the pain group, two from the gastrointestinal group, and at least one each from the other two groups. Most patients will have far more symptoms than eight. Symptoms require treatment or impair social, personal, or occupational functioning.
- DSM-IV required an onset by age 30, but most patients have been ill from their teens or early 20s on. SD symptoms must be unexplained by any medical condition (including substance misuse). Patients who also

have actual physical illnesses often react to them with greater anxiety than you might expect.

- Of course, actual physical illness should be first on the list of differential diagnoses. And, because SD can be difficult to treat, there are many other mental and emotional disorders that need to be ruled out. These include mood or anxiety disorders, psychotic disorders, and dissociative or stress disorders. Substance use disorders can be comorbid with SD. I would include factitious disorder and malingering on the differential list, but these belong very near the bottom.

With Predominant Pain Specifier for Somatic Symptom Disorder

Some patients with SSD experience mainly pain, in which case the specifier *with predominant pain* is indicated. DSM-IV called it pain disorder, an independent condition with its own criteria. (From here on, I refer to it as SSD–Pain.) Whatever we call it, we need to keep in mind these facts:

- Pain is subjective—individuals experience it differently.
- There is no gross anatomical pathology.
- Measuring pain is hard.

So it's hard to know that a patient who complains of chronic or excruciating pain, and apparently lacks adequate objective pathology, has a mental disorder at all. (In DSM-5, patients who have actual pain but show excessive concern can be diagnosed with SSD–Pain.)

The pain in question is usually chronic and often severe. It can take many forms, but especially common is pain in the lower back, head, pelvis, or temporomandibular joint. Typically, SSD-Pain doesn't wax and wane with time and doesn't diminish with distraction; it may respond only poorly to analgesics, if at all.

Chronic pain interferes with cognition, causing people to have trouble with memory, concentration, and completing tasks. It is often associated with depression, anxiety, and low self-esteem; sleep may be disturbed. Such patients may experience slower response to stimuli; fear of worsening pain may reduce their physical activity. Of course, work suffers. In over half the cases, chronic pain is managed inadequately by clinicians.

SSD–Pain usually begins in the 30s or 40s, often following an accident or some other physical illness. It is more often diagnosed in women than in men. As its duration extends, it often leads to increasing incapacity for work and social life, and sometimes to complete invalidism. Although some form of pain affects many adults in the general population—perhaps as high as 30% in the United States—no one knows for sure the prevalence of SSD–Pain.

Ruby Bissell

Ruby Bissell placed a hand on each chair arm and shifted uncomfortably. She had been talking for nearly half an hour, and the dull, constant ache had worsened. Pushing up with both hands, she hoisted herself to her feet. She winced as she pressed a fist into the small of her back; the furrows on her face added a decade to her 45 years.

Although Ruby had had this problem for nearly 6 years, she wasn't sure exactly when it began. It could have started when she helped to move a patient from the operating table to a gurney. But the first orthopedist she ever consulted explained that her pulled ligament was mild, so she continued to work as an operating room nurse for nearly a year. Her back hurt whether she was sitting or standing, so she'd had to resign from her job; she couldn't maintain any physical position longer than a few minutes at a time.

"They let me do supervisory work for a while," she said, "but I had to quit that, too. My only choices were sitting or standing, and I have to spend part of each hour flat on my back."

From her solidly blue-collar parents, Ruby had inherited a work ethic. She'd supported herself from the age of 17, so her forced retirement had been a blow. But she couldn't say she felt depressed about it. In fact, she had never been very introspective about her feelings and couldn't really explain how she felt about many things. She did deny ever having hallucinations or delusions: aside from her

back pain, her physical health had been good. Although she occasionally awakened at night with back pain, she had no real insomnia; appetite and weight had been normal. When the interviewer asked whether she had ever had death wishes or suicidal ideas, she was a little offended and strongly denied them.

A variety of treatments had made little difference in Ruby's condition. Pain medication provided almost no relief at all, and she had quit them all before she could get hooked. Physical therapy made her hurt all the more, and an electrical stimulation unit seemed to burn her skin.

A neurosurgeon had found no anatomical pathology and explained to Ruby that a laminectomy and spinal fusion were unlikely to improve matters. Her own husband's experience had caused her to distrust any surgical intervention. He had been injured in a trucking accident a year before her own difficulty began; his subsequent laminectomy had left him not only disabled for work, but impotent. With no children to support, the two lived in reasonable comfort on their combined disability incomes.

"Mostly we just stay at home," Ruby remarked. "We care a lot for each other. Our relationship is the one part of my life that's really good."

The interviewer asked whether they were still able to have any sort of a sex life. Ruby admitted that they did not. "We used to be very active, and I enjoyed it a lot. After his accident, and he couldn't perform, Gregory felt terribly guilty that he couldn't satisfy me. Now my back pain would keep me from having sex, regardless. It's almost a relief that he doesn't have to bear all the responsibility."

Evaluation of Ruby Bissell

For several years (far longer than the 6 months required by SSD criterion C), Ruby had complained of severe pain (A) that had markedly affected her life, especially her ability to work. She had clearly spent a great deal of time and effort (B) trying to manage her pain. There, in a nutshell, we've covered the three requirements for SSD-Pain.

Although the criteria don't require us to rule out other causes, we're responsible clinicians, so of course we will do so anyway. Principally, we need to know that her pain wasn't caused by **another medical condition**. The vignette makes clear that she had been thoroughly evaluated by her orthopedist, who determined that she did not have pathology adequate to account for the severity of her symptoms. (Even if she did have some defined pathology, SSD-Pain might also be suspected if the distribution, timing, or description of the pain was atypical of a physical illness.)

Could Ruby have been **malinger**ing? This question is especially relevant to anyone who receives compensation for a work-related injury. However, Ruby's suffering seemed genuine, and the vignette gives no indication that she was physically more able-bodied at leisure than at work. Her referral had not been made within a legal context, and she cooperated fully with the examination. Furthermore, malingering would not seem consistent with her long-held work ethic.

Pain is often a symptom of **depression**; indeed, many practitioners will automatically recommend a course of antidepressant medication for nearly anyone who complains of severe or chronic pain. Although Ruby denied feeling especially depressed, her pain symptoms could still be a stand-in for a mood disorder. But she had no suicidal ideas, disturbance of sleep, or disturbance of appetite that would support such a diagnosis. Although patients with substance-related disorders will sometimes fabricate (or imagine) pain in order to obtain medications, Ruby had been careful to avoid becoming dependent on analgesics.

Several other somatic symptom disorders should be briefly considered. People with **illness anxiety disorder** tend to have symptoms other than pain, and they fluctuate with time. Pain is not a symptom typical of **conversion disorder**. People with **adjustment disorder** will sometimes have physical symptoms, but such conditions are associated with identifiable precipitants and disappear with the stressor.

DSM-5 doesn't require us to identify psychological factors that could underlie pain. Indeed, the presumption that there be a psychological mechanism is no longer a criterion for SSD. It is useful, however, to think about possible psychological factors that could contribute to the production or maintenance of a given patient's pain experience. Ruby's history includes several such possibilities. These included her perception of her husband's feeling about his impotence, her anxiety at being left

as the sole breadwinner, and possibly her own resentment at having worked since she was a teenager. (Many patients have multiple psychological considerations.)

Psychological factors that might be causing or worsening Ruby's pain thus include stress resulting from relationships, work, and finances. With her GAF score of 61, her diagnosis would be as follows:

F45.1 [300.82]
Z65.8 [V62.89]

Somatic symptom disorder, with predominant pain
Health problems and disability in husband

An occasional patient like Ruby will be completely unable to describe the emotional component of pain. The inability to verbalize the emotions one feels has been termed *alexithymia*, Greek for “without expression of mood.”

F45.21 [300.7] Illness Anxiety Disorder

People with illness anxiety disorder (IAD) are terribly worried that they might have a serious illness. Their anxiety persists despite medical evidence to the contrary and reassurance from health care professionals. Common examples include fear of heart disease (which might start with an occasional heart palpitation) and of cancer (ever wonder about that mole—it seems to have darkened a bit?). These patients are not psychotic: They may agree temporarily that their symptoms could be emotional in origin, though they quickly revert to their fearful obsessing. Then they reject any suggestion that they do not have physical disease, and may even become outraged and refuse mental health consultation.

Many such patients have physical symptoms that would qualify them for somatic symptom disorder, as just discussed. However, about a quarter of such patients have all the concern about being sick, but not much in the way of somatic symptoms. Occasionally patients will have demonstrable organic disease, but their hypochondriacal symptoms are out of proportion to the seriousness of the actual medical condition. To delineate these patients more clearly, the condition has been renamed (*hypochondria* is considered pejorative), and new criteria have been written.

Though known for centuries, IAD still hasn't been carefully studied; for example, it isn't even known whether it runs in families. By all accounts, however, it is fairly common (perhaps 5% of the general population), especially in the offices of non-mental health practitioners. It tends to begin in the 20s or 30s, with peak prevalence at about 30 or 40. It is probably about equally frequent in men and women. Although they do not have high rates of current medical illnesses, such patients report a high prevalence of childhood illness.

Historically, hypochondriasis has been a source of fun for cartoonists and playwrights (read Molière's *The Imaginary Invalid*), but in reality the disorder causes genuine misery. Although it can resolve completely, it more often runs a chronic course, for years interfering with work and social life. Many patients go from doctor to doctor in the effort to find someone who will relieve them of the serious disorders they feel sure they have; for a few, like Molière's poor creature, Argan, it leads to complete invalidism.

Essential Features of Illness Anxiety Disorder

Despite the absence of serious physical symptoms, the patient is inordinately concerned about being ill. High anxiety coupled with a low threshold for alarm yields recurring behaviors concerning health (seeking reassurance, checking over and over for physical signs). Some patients cope instead by avoiding hospitals and medical appointments.

The Fine Print

The D's: • Duration (6+ months, though the concerns may vary) • Differential diagnosis (substance use and physical disorders, mood or anxiety disorders, psychotic or stress disorders, body dysmorphic disorder, somatic symptom disorder)

Coding Notes

Specify subtype:

Care-seeking type. The patient uses medical services more than normal.

Care-avoidant type. Due to heightened anxiety levels, the patient avoids seeking medical care.

Julian Fenster

“Wow! That chart must be 2 inches thick.” Julian Fenster was being checked in for his third emergency room visit in the past month. “That’s just Volume 3,” the nurse told him.

At age 24, Julian lived with his mother and a teenage sister. Years ago, he’d started attending a college several hundred miles away. After only a semester, he’d moved back home. “I didn’t want to be that far from my doctors,” he remarked. “When you’re trying to prevent heart disease, you can’t be too careful.” With a practiced hand, he adjusted the blood pressure cuff around his upper arm.

When Julian was a young teenager, his dad had died. “His death was self-inflicted,” Julian pointed out. “He’d had rheumatic fever as a child, which gave him an enlarged heart. And the only thing he ever exercised was his right to eat anything fried, including Twinkies. And he smoked—he was a proud two-pack-a-day man. Look where that got him.”

None of these health risks applied to Julian, who was nothing if not careful about what he put into his body. He had spent hours searching the Internet for information on diet, and he’d attended a lecture by Dean Ornish. “I’ve followed a plant-based diet ever since,” Julian said. “I’m especially keen on tofu. And broccoli.”

Julian had never complained much of symptoms—just the odd palpitation, maybe “hot flushes” on an especially humid day. “I don’t feel bad,” he explained. “I just feel scared.”

This time, he’d heard a report on NPR about young people with heart disease. It had startled him so much he’d dropped the dish he had been putting into the cupboard. Without even cleaning up the mess, he caught the next bus to the ER.

Julian agreed that he needed a different approach to his health care needs, and thought he might be willing to give cognitive-behavioral therapy a try. “But first,” he asked, “could you check my blood pressure just once more?”

Evaluation of Julian Fenster

The requirements for IAD are not onerous; Julian met them handily. He had a disproportionate concern for a condition he had been assured he did not have (criterion A). He had both high anxiety and a low threshold for alarm (it took only a report on the radio to frighten him into the ER once again, C). His actual symptoms weren’t just mild—they were pretty much nonexistent (B)—so we can rule out **somatic symptom disorder**. He invested huge amounts of time in trolling the Internet for health information (D). Finally, he had had these symptoms far longer than the 6-month minimum required (E) for the diagnosis of IAD.

As with any other condition discussed in this chapter (other than the disparaged [by me] somatic symptom disorder), the first issue on our list to rule out is **another medical condition**: Marked, if not inordinate, health anxiety is pretty common in medical outpatients. Physical illnesses can be easy to miss, especially if the patient has had a long history of complaints that seem without physical basis. However, Julian’s symptoms had been evaluated over and over again, to the point that there was little danger anything had been missed. Still, even people with hypochondriacal behavior are not immortal, so physical disorders would remain a significant rule-out that his clinicians must always keep in mind.

Anxious concern about health can occur in other mental disorders, but we can find some differences to help discriminate. Among these are **body dysmorphic disorder** and anxiety and related disorders (for example, **generalized anxiety disorder**, **panic disorder**, and **obsessive-compulsive disorder**). Julian had no symptoms suggesting any of these. When somatic concerns emerge in **schizophrenia**, they tend to be delusional and bizarre (“My brain is turning to bread”). In

major depressive disorder, they are ego-syntonic but may be influenced by melancholia (“My bowels have turned to cement”). As keen as I am on looking for depression in almost every mental health patient, I don’t see depressive symptoms here. I’d give him a GAF score of 65.

The girth of Julian's chart would support the care-seeking subtype specifier.

F45.21 [300.7]

Illness anxiety disorder, care-seeking type

Conversion Disorder (Functional Neurological Symptom Disorder)

Let's define a conversion symptom as (1) a change in how the body functions when (2) no causative physical or physiological malfunctioning can be found. These symptoms are often termed *pseudoneurological*, and they include both sensory and motor symptoms—with or without impaired consciousness.

Conversion symptoms usually don't conform to the anatomical pattern we'd expect for a condition with a well-defined physical cause. An example would be a *stocking anesthesia*, in which the patient complains of numbness of the foot that ends abruptly in a line encircling the lower leg. The actual pattern of nerve supply to the foot is quite different; it would not occasion numbness defined by such a neat line. Other examples of sensory conversion symptoms include blindness, deafness, double vision, and hallucinations. Examples of motor deficits that are conversion symptoms include impaired balance or staggering gait (at one time called *astasia-abasia*), weak or paralyzed muscles, lump in throat or trouble swallowing, loss of voice, and retention of urine.

For decades, criteria for conversion disorder required the clinician to judge that causation by an emotional conflict or specific psychological stress cause the conversion symptom (for example, a man develops blindness after finding his wife in bed with a neighbor). DSM-5 has abandoned this requirement, in view of the potential for disagreement as to causation: One clinician may see a “causal link” between nearly any two events, while another strenuously argues against any such connection.

Conversion symptoms occur widely, throughout various medical populations; up to one-third of adults have had at least one such symptom lifetime. However, conversion disorder is rarely diagnosed in mental health patients—perhaps in only 1 of 10,000. It is usually a disorder of young people and is probably far more common among women than men. It is somewhat more likely to be found in patients who are undereducated and medically unsophisticated, and who live where medical practice and diagnosis are still emerging. It may be diagnosed more often among patients seen in consultation in a general hospital.

Note that the criteria don't require patients to undergo laboratory or imaging tests. The requirement is only that, after a careful physical and neurological evaluation, the patient's symptom cannot be explained by a known medical or neurological disease process. The stocking anesthesia I have mentioned above would fill that requirement; so would total blindness in a patient whose pupils constrict in response to a bright light. There is a rich and entertaining literature of clinical tests for pseudoneurological symptoms.

Having a conversion symptom may not allow meaningful predictions about a patient's future course. Follow-up studies find that many people who have had a conversion symptom do not have a mental disorder. Years later, many are well, with no physical or mental disorders. Some have somatization (or somatic symptom) disorder or another mental disorder. A few turn out to have an actual physical (sometimes neurological) illness, including brain or spinal cord tumors, multiple sclerosis, or a variety of other medical and neurological disorders. Although clinicians have undoubtedly improved in their ability to discriminate conversion symptoms from "real disease," it remains distressingly easy to make mistakes.

Essential Features of Conversion Disorder

The patient's symptom or symptoms—changes in sensory or voluntary motor functioning—seem clinically inconsistent with any known medical illness.

The Fine Print

A “normal” exam or a bizarre test result isn’t enough to affirm the diagnosis; there must be positive supportive evidence. Such evidence would include a change in findings from positive to negative when a different test is used (or the patient is distracted), or impossible findings such as tunnel vision.

The D’s: • Distress or disability (work/educational, social, or personal impairment) • Differential diagnosis (substance use and physical disorders, mood or anxiety disorders, body dysmorphic and dissociative disorders)

Coding Notes

Specify if:

Acute episode. Symptoms have lasted under 6 months.

Persistent. Symptoms have lasted 6+ months.

Specify: {With}{Without} psychological stressor

Specify type of symptom:

F44.4 [300.11] With weakness or paralysis; with abnormal movement (tremor, dystonia, abnormal gait);
with swallowing symptoms; or with speech symptom

F44.5 [300.11] With attacks or seizures

F44.6 [300.11] With anesthesia or sensory loss; or with special sensory symptom (hallucinations or other disturbance of vision, hearing, smell)

F44.7 [300.11] With mixed symptoms

There’s something missing from the DSM-5 criteria for conversion disorder. In DSM-IV, we clinicians had to rule out intentional production of symptoms—specifically, malingering and factitious disorder. Although we are still asked to assure ourselves that no other diagnosis better explains the symptom, those two diagnoses aren’t explicitly mentioned. In my opinion, this is a good thing, because it’s hard (sometimes impossible) to determine for sure that a patient is faking. But with conversion symptoms, we should always keep the possibility in mind and do all we can to rule it out, along with every other confounding diagnosis.

Rosalind Noonan

Rosalind Noonan came to her university’s student health service because of a stutter. This was remarkable because she was 18 and she had only been stuttering for 2 days.

It had begun on Tuesday afternoon during her women’s issues seminar. The class had been discussing sexual harassment, which gradually led to a consideration of sexual molestation. To foster discussion, the graduate student leading the seminar asked each participant to comment. When Rosalind’s turn came, she stuttered so badly that she gave up trying to talk at all.

“I still ca-ca-ca-can’t understand it,” she told the interviewer. “It’s the first time I’ve ever had this pr-pr-pro—difficulty.”

Rosalind was a first-year student who had decided to major in psychology, she said, “to help me learn more about myself.” What she already knew included the following.

Rosalind had no information about her biological parents. She had been adopted when she was only a week old by a high school physics teacher and his wife, who had no other children. Her father was a rigid and perfectionistic man who dominated both Rosalind and her mother.

As a young child, Rosalind was overly active; during her early school years she’d had difficulty focusing her attention. She would probably have qualified for a diagnosis of attention-deficit/hyperactivity disorder, but the only evaluation she had ever had was from their family physician, who thought it was “just a phase” that she would soon outgrow. Despite that lack of diagnostic rigor, when she was 12 she did begin to grow out of it. By the time she entered high school, she was doing nearly straight-A work.

Although she had had many friends in high school and had dated extensively, she’d never had a serious boyfriend. Her physical health had been excellent, and her only visits to doctors had been for

[illegible]

03/03/2

F44.4 [300.11]

Conversion disorder, with speech symptom (stuttering), acute episode, with psychological stressor (concerns about molestation)

F54 [316] Psychological Factors Affecting Other Medical Conditions

Mental health professionals deal with all sorts of problems that can influence the course or care of a medical condition. The diagnosis of psychological factors affecting other medical conditions can be used to identify such patients. Although it is coded as a mental disorder and with mental disorders, it does not actually constitute one, so I've not provided a full vignette—just a few snippets to illustrate how the diagnosis might be applied. In truth, this condition should have been given a Z-code and stuck in the back with other such conditions, but that wasn't a possibility: ICD-10 makes the rules. Still, it doesn't belong up in the front seat, either.

Essential Features of Psychological Factors Affecting Other Medical Conditions

A physical symptom or illness is affected by a psychological or behavioral factor that precipitates, worsens, interferes with, or extends the patient's need for treatment.

The Fine Print

The D's: • Differential diagnosis (other mental disorders, such as panic disorder, mood disorders, other somatic symptom and related disorders, posttraumatic stress disorder)

Coding Notes

Specify current severity:

Mild. The factor increases medical risk.

Moderate. The factor worsens the medical condition.

Severe. It causes an ER visit or hospitalization.

Extreme. It results in severe, life-endangering risk.

Code the name of the relevant medical condition first.

Some Examples

DSM-IV included six specific categories of factors that could change the course of a medical condition. Partly because they were hardly ever used, DSM-5 has ditched these categories. However, I've used them as examples that might alert clinicians to the sorts of issue that can affect treatment decisions. If more than one psychological factor is present, choose the one most prominent.

Mental disorder. For 15 years Philip's compliance with treatment for schizophrenia has been spotty. Now his voices warn him to refuse dialysis.

Psychological symptoms (insufficient for a DSM-5 diagnosis). With few other mental symptoms, Alice's mood has been so low that she hasn't bothered filling prescriptions for her type II diabetes.

Personality traits or coping style. Gordon's lifelong hatred of authority figures has led him to reject his doctor's recommendation for a stent.

Maladaptive health behaviors. Weighing nearly 400 pounds, Tim knows that he should avoid sweetened drinks, but nearly every day his love of Big Gulps wins out.

Stress-related physiological response. April's job as the Governor's spokesperson is so demanding that she's had to double up on her antihypertensive drugs.

Other or unspecified psychological factors. Harold's religion prohibits him from accepting a blood transfusion. In Nanja's culture, a woman mustn't allow any man not her husband to see her unclothed; her internist is Derek.

Of course, you might find a psychological factor or two at play in nearly any medical condition. To use this diagnosis effectively, reserve it for situations in which it is clear that the psychological factor is adversely influencing the course of the illness.

F68.10 [300.19] Factitious Disorder

Factitious means something artificial. In the context of mental health patients, it means that a disorder looks like bona fide disease, but isn't. Such patients accomplish this by simulating symptoms (for example, complaining of pain) or physical signs (for instance, warming a thermometer in coffee or submitting a urine specimen that's been supplemented with sand). Sometimes they will complain of psychological symptoms, including depression, hallucinations, delusions, anxiety, suicidal ideas, and disorganized behavior. Because they are subjective, manufactured mental symptoms can be very hard to detect.

DSM-5 includes two subtypes of factitious disorder: one in which behaviors affect the person of the perpetrator, and one in which the behaviors affect another individual.

Factitious Disorder Imposed on Self

People affected by factitious disorder imposed on self (FDIS) can have remarkably dramatic symptoms, accompanied by outright lying about the severity of the distress. The overall pattern of signs and symptoms may be atypical for the alleged illness, and some patients change their stories upon retelling; either sort of evidence of inconsistency aids identification. Other patients with FDIS, however, know a lot about the symptoms and terminology of disease, which can make their behavior harder to detect. Some willingly undergo many procedures (some of them painful or dangerous) to continue in the patient role. With treatment that is ordinarily adequate to address their "disease," their symptoms either do not remit or evolve into new complications.

Once hospitalized, patients with FDIS often tend to complain bitterly and to argue with staff members. They characteristically remain hospitalized for a few days, have few if any visitors, and leave against medical advice once their tests prove negative. Many travel from city to city in the quest for medical care. The most persistent travelers and confabulators among these are sometimes said to have Münchhausen's syndrome, named for the fabled baron who told outrageous lies about his adventures.

Contrary to its immediate predecessor, DSM-5 doesn't require speculation as to possible motives for FDIS (or its sibling, FDIA, discussed below)—a blessing for those clinicians who reject the implication that they can read minds. It is enough to detect a pattern of such behavior in a patient whose behavior involves no other person.

Patients with FDIS differ profoundly from malingerers, who may show some of the same behaviors—silting a urine specimen, embellishing the subjective reports of their suffering. However, malingerers do these things to qualify for financial compensation (such as insurance payments), to obtain drugs, or to avoid work, punishment, or, in days gone by, military service. The motivation in FDIS is apparently more complex: These patients may need the feeling of being cared for, of duping medical personnel, or simply of receiving a whole lot of attention from important people. For whatever reason, they manufacture physical or psychological symptoms in a way that they may claim they cannot control.

The diagnosis of FDIS is made by excluding physical disease and other disorders. (Although it is

[illegible]

03/03/

The Fine Print

Coding Notes

Factitious disorder imposed on self. The perpetrator is also the patient.

For either type, specify:

Single episode.

Recurrent episodes.

Jason Bird

Jason Bird carried no health care card—he claimed he had lost his billfold to a mugger a few hours before he came to the emergency room of a Midwestern hospital late one Saturday night, complaining of crushing substernal chest pain. Although his electrocardiogram (EKG) was markedly abnormal, it did not show the changes typical of an acute myocardial infarction. The cardiologist on call, noting his ashen pallor and obvious distress, ordered him admitted to the cardiac ICU, then waited for the cardiac enzyme results.

The following day, Jason's EKG was unchanged, and the serum enzymes showed no evidence of heart muscle damage. His chest pain continued. He complained loudly that he was being ignored. The cardiologist urgently requested a mental health consultation.

At age 47, Jason was a slightly built man with a bright, shifting gaze and a 4-day growth of beard. He spoke with a nasal Boston accent. His right shoulder bore the tattoo of a boot and the legend "Born To Kick Ass." Throughout the interview he frequently complained of chest pain, but he breathed and talked normally, and he showed no evident anxiety about his medical condition.

He said he had grown up in Quincy, Massachusetts, the son of a physician. After high school he had attended college for several years, but found he was “too creative” to stick with a profession or a conventional job. Instead, he had turned to inventing medical devices, and numbered among his successes a positive-pressure respirator that bore his name. Although he had made several fortunes, he had lost nearly everything to his penchant for playing the stock market. He had been visiting in the area, relaxing, when the chest pain struck.

"And you've never had it before?" asked the interviewer, looking through the chart.

Jason denied that he'd had any previous heart trouble. "Not even a twinge. I've always been blessed with good health."

"Ever been hospitalized?"

"Nope. Well, not since a tonsillectomy when I was a kid."

Further questioning was similarly unproductive. As the interviewer left, Jason was demanding extra meal service.

Playing a hunch, the interviewer began telephoning emergency room physicians in the Boston area to ask about a patient with Jason's name or peculiar tattoo. The third try struck pay dirt

“Jason Bird? I wondered when we’d hear from him again. He’s been in and out of half the facilities in the state. His funny-looking EKG—probably an old MI—looks pretty bad, so he always gets admitted, but there’s never any evidence that anything acute is going on. I don’t think he’s addicted. A couple of years ago, he was admitted for a genuine pneumonia and got through a week without pain medication and with no withdrawal symptoms. He’ll stay in the ICU a couple of days and rag on the staff. Then he’ll split. He seems to enjoy needling medical people.”

“He told me that he was the son of a physician and that he was a wealthy inventor.”

The voice on the other end of the line chuckled. “The old respirator story. I checked into that one when he was admitted here for the third time. That was a different Bird altogether. I don’t know that Jason’s ever invented anything in his life—other than his medical history. As for his father, I think he was a chiropractor.”

Returning to the ward to add a note to the chart, the interviewer discovered that Jason had discharged himself against advice and departed, leaving behind a letter of complaint to the hospital administrator.

Evaluation of Jason Bird

Jason illustrates the principal difficulty of diagnosing factitious disorder: The criteria depend heavily on the clinician’s ability to determine that the signs and symptoms presented are intentionally falsified (criterion A). Sometimes that’s easy, as when you find the patient scratching open a wound or parking the thermometer on a radiator. But often the intent to deceive must be inferred, as in Jason’s case, from a string of visits to diverse health care facilities for the same complaint. Jason’s EKG did not change and his cardiac enzymes were not elevated, so his interviewer inferred that Jason was feigning or markedly exaggerating his chest pain. That assumption may have been correct, but it was supported not by proof, only by reports from the emergency room.

Jason presented himself as ill (B), even in the absence of external motivation such as monetary gain or escape from punishment (C). That was important, for such behavior is the principal ingredient that differentiates factitious disorder from **malinger**ing—which of course we must consider, if only to refute it. Malingering carries with it no criteria, but we commonly agree that it occurs when a person consciously pretends to have a disorder in order to gain something of value: money (from insurance, a lawsuit, compensation); drugs (from a sympathetic physician); avoidance of a conviction for a crime; or release from, for example, military service. For Jason, no such gain was apparent.

The list of other differential diagnoses is predictable. Most important, of course, FDIS must be differentiated from **physical illnesses**. This was soon accomplished in Jason’s case. Then other mental disorders must be ruled out. Patients with **somatic symptom disorder** may also complain of symptoms that have no apparent organic basis. Those with **antisocial personality disorder** may lie about symptoms, but they usually have some material gain in mind (to avoid punishment, to obtain money). Some patients with **schizophrenia** have a bizarre lifestyle that could be confused with the wanderings of classic Münchhausen’s syndrome, but their content of thought will usually include clear delusions and hallucinations. Patients who feign psychological symptoms may look as though they have **dementia** or **brief psychotic disorder**. None of these disorders could be supported by Jason’s history or cross-sectional presentation.

Several other disorders may accompany FDIS. These include **substance-related disorders** (involving sedatives and analgesics) and **dependent, histrionic, and borderline personality disorders**. Many patients with FDIS have a serious personality disorder, but of course we have far too little information for such a diagnosis in Jason’s case. We’d need to mention the possibility in the summary we dictate. With a GAF score of 41, here is how I’d diagnose Jason Bird:

F68.10 [300.19]

Factitious disorder imposed on self

Claudia Frankel

Police reports are usually pretty dry; they don’t often moisten the eye. The Frankel case proved the exception to that rule.

When Rose Frankel was only 2 years old, she began to experience intestinal and other symptoms that would fill the next 6 years of her life. It started with spells of vomiting that seemed intractable to treatment. In all, she was carried back and forth to the pediatrician's office, and frequently to the hospital, some 200 times. Each visit led to new tests, new attempts at treatment that led nowhere. She had undergone nearly two dozen operative procedures, and swallowed numerous medications for diarrhea, infections, seizures, and spells of vomiting, when finally nurses on the pediatric intensive care unit noticed that Rose would appear to be on the mend until her mother, Claudia, arrived and would take her to a private room. They'd hear Rose crying, and her health would take another turn for the worse—sometimes, just when she was thought ready for discharge.

In all, Rose suffered nearly a dozen serious infections; one of them, a life-threatening sepsis, involved multiple organisms. Through it all, Claudia worked closely with their family doctor. They would speak in person or on the phone several times a day, and Dr. Bhend often spoke of Claudia as his “good right arm” in trying to get to the bottom of the calamity that was engulfing their patient.

During the 4 years of her medical ordeal, the only time that Rose remained healthy longer than a month was when Claudia left town to nurse her own mother, during what proved to be that old lady's final illness. For the last few weeks of her kindergarten year, Rose bloomed. But she sickened again, shortly after Grandma died and Claudia returned home.

Several on the hospital nursing staff were beyond suspicious. Once, they'd found a bottle of Ipecac discarded in the room Rose had occupied. On another occasion, a monitoring device that three staff members had checked within the hour had been found turned off. As they told the investigating officers, most staff members had concluded that Claudia was directly responsible for her daughter's illness, so they hid a camera in the private room Claudia always used during Rose's many admissions. When he found out, Dr. Bhend, concerned about the loss of trust, warned Claudia of the “impending sting.” That afternoon, she checked Rose out of the hospital, and they were lost to follow-up. The staff revealed the full details to the police, who opened a file but were never able to pull together solid information.

FDIA is just one of the new DSM-5 disorders that was included in an appendix of DSM-IV as a possible diagnosis that needed further study. Also making the big time after years of study are premenstrual dysphoric disorder, mild neurocognitive disorder, binge-eating disorder, and (my personal favorite) caffeine withdrawal. Welcome aboard, all!

Evaluation of Claudia Frankel

Two of the criteria required for a diagnosis of factitious disorder were easily satisfied. There was nothing to suggest an external reward for Claudia's behavior such as financial gain (criterion C), and she certainly did present Rose as being impaired (D). Two others we have to take on faith: although the circumstantial evidence was strong that Rose's symptoms were fabricated, the staff just missed nailing down the proof (A). And, we cannot be sure that Claudia had no other mental disorder such as a delusional disorder that could better explain her behavior (D). Therefore, our current diagnosis should be treated as provisional. I would make a note in her chart to the effect that further investigation would be needed in regard to a personality disorder; in ICD-10, we can no longer code “diagnosis deferred” in that category.

Assigning Claudia's GAF score prompts some discussion. Should we base our judgment on the fact that she was able to function well in most areas of her life, or on the effect of her behavior on Jennifer and on their relationship? In my opinion, the disastrous consequences of her impaired judgment would be the deciding factor here; hence the very low GAF score of 30. However, others might see her situation quite differently and choose to argue.

Note that Rose herself would be given the code Z69.010 [V61.21] to reflect the fact that she had suffered from physical abuse by a parent.

F45.8 [300.89] Other Specified Somatic Symptom and Related Disorder

This category is for patients whose somatic symptoms do not fulfill criteria for any of the somatic symptom and related disorders discussed above, but about which we have some information. Any diagnosis suggested here has not as yet been studied enough for formal inclusion in DSM-5, and should be considered provisional. Keep in mind that with more information, such a patient may qualify for a diagnosis in a different chapter or for another diagnosis in this one.

Pseudocyesis. The word *pseudocyesis* means “false pregnancy,” and it refers to patients’ incorrect belief that they are pregnant. They develop signs of pregnancy such as protruding abdomen, nausea, amenorrhea, and breast engorgement—and even symptoms such as the sensation of fetal movement and labor pains.

Brief illness anxiety disorder. Duration less than 6 months.

Brief somatic symptom disorder. I'll leave the definition as homework.

F45.9 [300.82] Unspecified Somatic Symptom Disorder

Use this category for cases in which full criteria for any of the disorders discussed in this chapter are not met, and you do not wish to specify a reason or a possible presentation.

*Much of the information presented here and elsewhere in this chapter is based on studies of patients defined by DSM-IV criteria. When DSM-5 criteria were written, there simply weren't data available for disorders defined by the new criteria.

CHAPTER 12

Sexual Dysfunctions

Quick Guide to the Sexual Dysfunctions

DSM-5 addresses three sorts of issues directly tied to sexual functioning. In DSM-IV and before, they were all included in the same chapter; now the sexual dysfunctions, gender dysphoria, and paraphilic disorders are spread out over three different chapters. As with most other diagnoses, patients can have problems in multiple areas, which can in turn coexist with other mental diagnoses.

With the exception of substance-induced sexual dysfunction, the sexual dysfunctions are gender-specific. DSM-5's organization is alphabetical; I've grouped these disorders by gender and stage in an act of sex at which the dysfunction occurs. The link indicates where a more detailed discussion begins.

Sexual Dysfunctions

Male hypoactive sexual desire disorder. The patient isn't much interested in sex, though his performance may be adequate once sexual activity has been initiated.

Erectile disorder. A man's erection isn't sufficient to begin or complete sexual relations.

Premature (early) ejaculation. A man experiences repeated instances of climax before, during, or just after penetration.

Delayed ejaculation. Despite a normal period of sexual excitement, a man's climax is either delayed or does not occur at all.

Female sexual interest/arousal disorder. A woman lacks interest in sex or does not become aroused enough.

Genito-pelvic pain/penetration disorder. Genital pain occurs (only in women) during sexual intercourse, often during insertion.

Female orgasmic disorder. Despite a normal period of sexual excitement, a woman's climax either is delayed or does not occur at all.

Substance/medication-induced sexual dysfunction. Many of these problems can also be caused by intoxication or withdrawal from alcohol or other substances.

Other specified, or unspecified, sexual dysfunction. These are catch-all categories for sexual problems that do not meet the criteria for any of the foregoing sexual dysfunctions.

Other Causes of Sexual Difficulties

Paraphilic disorders. These include a variety of behaviors that most people regard as distasteful, unusual, or abnormal. Nearly all are practiced almost exclusively by males.

Gender dysphoria. Some people strongly identify so strongly with the opposite gender that they are uncomfortable with their assigned gender roles.

Nonsexual mental disorders. Many patients develop sexual dysfunctions as a result of other mental disorders. Lack of interest in sex may be encountered especially in somatic symptom disorder, major depressive disorder, and schizophrenia.

can achieve an erection only under certain circumstances (for example, with prostitutes). ED is probably the most prevalent male sexual disorder, occurring at least occasionally in perhaps 2% of *young* men; that number does not improve with age. Of all the sexual dysfunctions, this is the one most likely to occur for the first time later in life.

A variety of emotions can play a role in the development or maintenance of ED. These include fear, anxiety, anger, guilt, and distrust of the sexual partner. Any of these feelings can so preoccupy a man's attention that he cannot focus adequately on feeling sexual pleasure. Even a single failure may lead to anticipatory anxiety, which then precipitates another round in the circle of failure. The prominent sex researchers Masters and Johnson also talked about a factor they called *spectatoring*, in which the patient evaluates his performance so constantly that he cannot concentrate on the enjoyment of sex. Such a patient might have an erection with foreplay but lose it upon penetration.

ED should not be diagnosed if biological factors are the principal or only cause. This is unlikely if erections occur spontaneously, with masturbation, or with other partners. Some authorities now estimate that half or more of patients who complain of impotence have a biological cause for it, such as prostatectomy for cancer. When psychological factors are judged to be a part of the cause, as is often the case, the diagnosis can be made.

Like the other sexual dysfunctions, ED can be either lifelong or acquired; the former is rare and hard to treat.

Essential Features of Erectile Disorder

The patient almost always has marked trouble achieving or maintaining an erection adequate to consummate sex.

The Fine Print

The D's: • Duration (6+ months) • Distress to the patient • Differential diagnosis (substance use and physical disorders, relationship problems, other mental disorders)

Coding Notes

Specify:

{Lifelong}{Acquired}
{Generalized}{Situational}

Specify severity of distress over the symptoms: {Mild}{Moderate}{Severe}

Parker Flynn

"I think I must be over the hill."

If you didn't count the three counseling sessions he had had while sifting through the wreckage of his first marriage, this was Parker Flynn's first visit ever to a mental health professional. At age 45 he had been a bridegroom for only 7 months, and he was afraid he was losing his sexual potency.

Everything had been fine before the wedding, but the first evening of their honeymoon, Parker had been unable to get enough of an erection to do either him or his wife much good. He supposed he'd had too much champagne—normally he didn't touch alcohol. His wife had also been married before and knew a thing or two about men. She hadn't criticized; she'd even said it would be all right. But she was attractive and 10 years younger than Parker, and he was worried: Most of the time since, he'd been unable to perform.

"Some of the guys warned me, it's what happens when you get older," Parker insisted. "That which should be easy is hard, and that which should be hard isn't."

Before he popped the question, he had undergone a complete physical examination. Other than being a few pounds overweight—Parker was devoted to chocolate ice cream—he was given a clean bill of health. Besides the ice cream, he denied any other addictions, including alcohol, drugs, and tobacco.

"I get so nervous when it's time to make love," Parker explained. "I can get a pretty good erection when we're fooling around, but when it's time to get serious, I lose it. Her first husband was something of a stud, and I keep wondering how my performance measures up to his."

Evaluation of Parker Flynn

Parker's interest in sex seemed to be just fine; he gave every indication (normal erections) that there was nothing wrong with the excitatory phase. But because he worried about maintaining his erection, he did have difficulty maintaining an erection (criterion A2) stressful enough that he sought care (C). His problem was exacerbated by the phenomenon of spectating (see above), in which his performance was affected by wondering how well he was doing while he was doing it. His problem had been present for 7 months—just qualifying for the DSM-5 time requirement (B, though in obvious cases I'd be a little relaxed about this requirement; it does say "approximately," after all).

Parker's physical condition was good, pretty much ruling out a causative **physical illness** (D). Some patients with impotence may suffer from **sleep apnea**; of course, it is vital to explore this possibility, because of the potentially lethal nature of that disorder. He had no previous mental health problems that would preclude the diagnosis of ED. His difficulty may have begun with an alcohol-related incident, but from his history, substance use played no role in its maintenance. Also note that, as they age, men may require more stimulation to achieve erection than they did when they were younger; such a physiological change should not constitute evidence of ED. **Sporadic erectile problems** that don't cause important distress also should not be given this diagnosis.

Parker's problem was not lifelong but acquired; the vignette provides no evidence that it applied only in specific situations, so neither situational nor generalized type would be specified. With no other obvious specifiers to note (and a GAF score of 70), his diagnosis would read:

F52.21 [302.72]

Erectile disorder, acquired

F52.4 [302.75] Premature (Early) Ejaculation

As the disorder's name implies, the man climaxes before he wants to—sometimes just as he and his partner reach the point of insertion. However, different studies use widely varying standards of how many minutes actually constitutes *early*: Is it 7 minutes? Is it 1? Both standards have been proposed. Whatever the duration, the climax yields disappointment and a sense of failure for both partners; secondary impotence sometimes follows. Stress in a relationship can exacerbate the condition, which of course promotes even greater loss of control. However, some women may value premature ejaculation (PE) because it decreases their exposure to unwanted sexual activity or pregnancy.

PE is a commonplace disorder; it accounts for nearly half the men treated for sexual disorders. It is especially frequent among men with more education—presumably because their social group is especially sensitive to the issue of partner satisfaction. Whereas anxiety is often a factor, physical illness or abnormalities rarely cause this problem.

Essential Features of Premature (Early) Ejaculation

The patient almost always ejaculates before he wants to, within moments of penetration.

The Fine Print

The D's: • Duration (6+ months) • Distress to the patient • Differential diagnosis (substance use and physical disorders)

Coding Notes

Specify:

(111111118) (123456789)

{Generalized}{Situational}

Specify severity:

Mild. The patient ejaculates 30–60 seconds after penetration.

Moderate. 15–30 seconds after penetration.

Severe. 15 seconds after penetration or less (perhaps before penetration).

Let's be practical. And honest. The official criteria state two time standards for the patient with premature ejaculation, which boil down to "about a minute" and "too early." DSM-5 claims that men can pretty accurately estimate time as long as it's a minute or less, and in the heat of the moment, it seems unlikely in the extreme that anyone is going to clap a stopwatch on the activity. Therefore, for the vast majority of our patients, we will eschew the clock and accept the statement that "I just flat-out come too soon."

Claude Campbell

Claude Campbell could remember, in embarrassing detail, the first time it ever happened. He had been a very young Marine second lieutenant stationed in Vietnam in the last year of the war. Suddenly granted leave to go to town, he had had to borrow a pair of Class A uniform trousers from the battalion chaplain.

Claude and two friends were seated at a sidewalk table, drinking a mixture that the military called a “Bombs Away,” when a prostitute sat down next to him. When she set to work warming her hand between his thighs, it only took a few moments before Claude felt himself lose control. A crimson blush spread across his face as a stain darkened the front of the chaplain’s khaki trousers.

“That was one of the worst times, but it sure wasn’t the last,” said Claude. After he left the Marines, he finished college and got a job selling computers. He soon married a girl he had dated during high school. Their wedding night, and most of their other nights, were never quite the disaster of the Vietnam bar, but he could never last longer than a minute or so after insertion.

“Not that it bothered her,” commented Claude ruefully. “She never enjoyed sex much, anyway. She was always glad to get it over with in a hurry. I know now why she insisted on ‘saving it’ for after we were married. She never wanted to spend it in the first place.”

Claude always hoped that his problems had been largely due to his first wife's prudery and disapproval, but several months into his new marriage, things hadn't improved much. "She's being very patient," he said, "but we're both beginning to get desperate."

Evaluation of Claude Campbell

Claude's difficulty had been with him ever since his sex life began, and it occurred every time (criterion B). Although a few such incidents might be dismissed in a youngster or in any man with a new partner, in a mature adult (we don't know Claude's age at evaluation) who has been in a lasting relationship with frequent sexual activity, it must be considered pathological (A). Claude's difficulty was clearly causing him distress (C); we'd have to enquire further about substance use (D). As noted earlier, **physical illness** does not play a significant role in the development of PE.

Claude's problem was not situational (it had occurred with both of his wives and with the prostitute). As far as we're aware, he'd had it forever. I'd place his GAF score at 70.

F52.4 [302.75]

Premature ejaculation, generalized, lifelong, moderate

F52.32 [302.74] Delayed Ejaculation

Men with delayed ejaculation (DE) achieve erection without difficulty, but have problems reaching orgasm. Some only take a long time; others may not be able to ejaculate into a partner at all. Prolonged friction may cause the partners of these patients to complain of soreness. Anxiety about

performance may cause secondary impotence in the patients themselves.

Even when it has been present lifelong, a man can usually ejaculate by masturbating (alone or with the help of his sex partner). The personalities of patients with lifelong DE have been described as rigid and puritanical; some seem to equate sex with sin. Or the disorder may be acquired from interpersonal difficulties, fear of pregnancy, or a partner's lack of sexual allure. DE is somewhat more common in patients with anxiety disorders.

DE is probably uncommon. When men do have problems with delayed (or absent) climax, there is often a medical cause; examples include hyperglycemia, prostatectomy, abdominal aortic surgery, Parkinson's disease, and spinal cord tumors. Some men have a physical abnormality that, upon orgasm, causes semen to be expelled into the urinary bladder (retrograde ejaculation). Drugs like alphamethyldopa (an antihypertensive) and thioridazine (a neuroleptic), as well as alcohol, have also been implicated. If any of these factors is the *sole* cause, it cannot be regarded as an example of DE.

The drug thioridazine, which can inhibit a man's ability to have orgasm, is sometimes used to treat patients with premature ejaculation (see the previous diagnosis).

Essential Features of Delayed Ejaculation

The man experiences pronounced delay or infrequency of climax.

The Fine Print

The D's: • Duration (6+ months) • Distress to the patient • Differential diagnosis (substance use and physical disorders, relationship problems)

Coding Notes

Specify:

{Lifelong}{Acquired}
{Generalized}{Situational}

Specify severity: {Mild} {Moderate} {Severe}

Rodney Stensrud

Rodney Stensrud and his girlfriend, Frannie, had come to the clinic seeking relief for Rodney's "performance problem." They had been together for nearly a year, and they disagreed as to the extent of the problem.

Rodney was frankly worried. It had always taken him a long time to have a climax, and now, after 40 minutes or so of vigorous intercourse, he sometimes found himself wilting under pressure. Frannie was more sanguine. Her previous boyfriend had never been able to last longer than 5 minutes, and that often left her feeling frustrated.

“Now I almost always come more than once,” she said with an air of satisfaction. Recently Rodney had been taking even longer, and she admitted that she was getting pretty sore. “Maybe if we could get it back down to about half an hour,” she suggested.

Rodney's parents had reared him strictly. Throughout his childhood, he had attended parochial school, so that he was "pretty clear on the concept of good versus evil." He admitted that he felt guilty that he and Frannie were living together without benefit of clergy, but she wasn't ready to take that step yet. She used to laugh and tell him that she wanted to "save something for after the baby came."

Before meeting Frannie, Rodney's only experience had been with two prostitutes he had encountered while he was in the Navy. It had taken him hardly any time at all with either of them. In fact, he felt that the one with the mouth had rather shortchanged him. "There sure wasn't any delay involved," he said. Neither had he experienced any particular problem masturbating, either when he

was an adolescent or more recently when Frannie was gone on an extended business trip.

Rodney had been referred by a urologist, who had found nothing physically wrong. The couple's only drinking was an occasional glass of white wine. At one time Rodney had occasionally used marijuana at parties, but Frannie was death on drugs, so he had given it up a year ago.

Evaluation of Rodney Stensrud

After apparently normal desire and excitement phases, Rodney always took an inordinately long time to reach climax (criterion A1). From the vignette, this does not appear to have been a lifelong problem, though it had now lasted for many months (B). The problem was causing him enough distress to seek help (C); already he seemed headed down the road to secondary impotence.

Rodney's problem was situational; he had experienced no ejaculatory delay when with a prostitute or when masturbating. His referring physician had noted no **physical illnesses** that might account for his disorder, and there was no significant **substance use**; with no evidence of any **other mental disorder** that might be diagnosed instead, we've exhausted the possibilities of criterion D. His upbringing was puritanical, reinforcing the impression that the basis of his disorder was psychological, not physical.

Frannie's reaction to Rodney's disorder was perhaps somewhat atypical. Female partners sometimes complain of discomfort from prolonged intercourse necessary to achieve climax. Would the fact that Frannie found value in Rodney's disorder present a possible problem for therapy? When working with the couple, Rodney's clinician should keep this factor in mind—along with the possibility that he could have an anxiety disorder.

Rodney's GAF score would be about 70. His diagnosis would be as follows:

F52.32 [302.74]

Delayed ejaculation, acquired, situational, moderate

F52.22 [302.72] Female Sexual Interest/Arousal Disorder

Female sexual interest/arousal disorder (FSIAD) represents the fusion of two older diagnoses: hypoactive sexual desire disorder and female sexual arousal disorder. DSM-5 has combined them for several reasons. Especially in women, there is a high overlap between desire and arousal; some authorities think of desire as just the cognitive component of arousal. Moreover, one phase doesn't always precede the other; their relationship really depends on the individual. And treating low desire also improves arousal.

Sexual desire depends upon a number of factors, including the patient's inherent drive and self-esteem, previous sexual satisfaction, an available partner, and a good relationship with the partner in areas other than sex. Sexual desire may be suppressed by long abstinence. It may present as infrequent sexual activity, or as a perception that the partner is unattractive. Some patients actually become averse to sex, expressing loathing of any genital contact or of aspects of genital sexual contact.

Lack of interest in sex is the most common complaint of women coming to treatment. About 30% of women ages 18–59 will admit to having a period of at least several months when they've lacked sexual desire. As a result, perhaps half feel distress, which can affect the individuals or their relationships. Low desire is greater for women who are postmenopausal (either naturally or after surgery). There may be a history of painful intercourse, feelings of guilt, or rape or other sexual trauma occurring in childhood or in a patient's earlier sexual life.

Don't diagnose FSIAD if the problem occurs only in the context of another mental condition, such as major depressive disorder or a substance use disorder. (Among the medications that can contribute are antihistamines and anticholinergics.) Also note that postmenopausal females may need more foreplay to lubricate to the same degree than they did when they were younger. However, FSIAD often coexists with another sexual condition, such as female orgasmic disorder. A woman who doesn't express interest in sex but does respond to sexual activity with excitement would not qualify for a diagnosis of FSIAD. Neither would someone who identifies herself as having been "asexual" her whole life.

Essential Features of Female Sexual Interest/Arousal Disorder

A woman's low sexual interest or arousal is indicated by minimal interest in sexual activity, erotic thoughts, response to partner overtures, and enjoyment during sex. She will generally not initiate sexual activity and doesn't "turn on" to erotic literature, movies, and the like.

The Fine Print

The D's: • Duration (6+ months) • Distress to the patient • Differential diagnosis (substance use and physical disorders, relationship problems)

Coding Notes

Specify:

{Lifelong}{Acquired}
{Generalized}{Situational}

Specify severity: {Mild}{Moderate}{Severe}

Ernestine Paget

"She hardly ever wants to do it," James Paget told the marriage therapist.

"That's not quite accurate," Ernestine responded. "The truth is, I never want to do it. It's disgusting."

When they got married 3 years earlier, Ernestine had been uninterested in sex, though receptive to the idea of it. "It seemed to mean a lot to him, so I put up with it," she explained. "But he was never satisfied. No matter how often we made love, a few days later there he was, wanting more. It got old fast."

"It is the usual expectation," her husband remarked dryly, "and it's not my fault how she was brought up."

In Ernestine's family, sex was never discussed and nudity wasn't allowed. Ernestine could never remember having much curiosity about sex, let alone interest. She had been an only child. "I assume her parents only did it once," offered James.

For the first few months, Ernestine would simply lie still and think about other things, enduring what was for her a basically boring activity because it was important to her new husband. Her gynecologist had assured her that as far as her anatomy and hormones were concerned, she was completely normal. Unless she was figuring out whether it was time to start taking her new prescription of birth control pills, she never thought about sex.

"God knows, I never dream about it," Ernestine said. "Maybe if he'd led up to it more, it would have helped. His idea of foreplay is half an hour of David Letterman and a slap on the butt." She had once tried to explain this to James, but he had only called her "frigid." That was the last word they had exchanged on the subject until now.

Now James pretty much ignored Ernestine. She undressed in the closet; they slept on the two edges of their king-sized bed. She didn't know where he was getting his sex these days, but it wasn't at home and she said she didn't care.

"At least he doesn't have to worry that I'd try to cut it off, like that Bobbitt woman," Ernestine said. "I don't even like to look at it, let alone touch it with a 10-inch knife."

Evaluation of Ernestine Paget

Ernestine's low sex interest was shown not just by absent interest (criterion A1); she denied even fantasizing (A2) about what was for her a boring activity (A4). This is an important point: Some patients may reject the idea of sex with a current (or with any) partner, yet may still harbor an abstract

husband 3 years earlier (B), she was merely uninterested in sex. It was only with experience that she became intolerant of the very idea of sexual contact, from which we can infer criterion A3. (Three of the six criterion A requirements for FSIAD must be met.) Although she could face the prospect of no sex with equanimity, her husband couldn't, and that disparity was causing distress for them both; criterion C was thus satisfied.

Ernestine's clinician needed to ascertain that she had no other major disorder—such as **major depressive disorder, somatic symptom disorder, or obsessive-compulsive disorder**—that could explain her antipathy to sex (D). In the presence of any of these, she'd only receive the additional diagnosis of FSIAD if her sexual symptoms remained once the other pathology had been eliminated. Similar arguments would hold for substance use or another medical condition.

The Pagets were also having severe problems with other aspects of their marriage—enough to warrant mention as a spousal relationship problem. Her abhorrence of sexual contact could also meet the criteria for **specific phobia**; under the circumstances, however, no such additional diagnosis is necessary. In DSM-IV, Ernestine would have qualified for a diagnosis of sexual aversion disorder, but DSM-5 has eliminated it.

Ernestine's condition appears to have lasted throughout her sexual life. With our current information, we couldn't determine whether her disorder was generalized or situational. Although we suspect that something in her upbringing may lie at its roots, in DSM-5 we have no way to code this putative etiology. With a current GAF score of 61, her diagnosis would be as follows:

F52.22 [302.72]
Z63.0 [V61.10]

Female sexual interest/arousal disorder, lifelong, severe
Relationship distress with husband (emotional withdrawal)

Disorders of female sexual arousal and orgasm are often highly correlated. Among health care clinicians, you may encounter less than slavish adherence to the criteria used for these disorders.

F52.6 [302.76] Genito-Pelvic Pain/Penetration Disorder

Genito-pelvic pain/penetration disorder (GPD), new in DSM-5, subsumes the DSM-IV categories of dyspareunia and vaginismus, which were combined because they couldn't be discriminated reliably. The old terms will probably retain some currency as descriptors of particular types of discomfort.

Some women experience marked discomfort when attempting to have sexual intercourse. The pain may be experienced as a cramping contraction of the vaginal muscles (vaginismus) that may be described as an ache, a twinge, or a sharp pain. Anxiety can produce tension in the pelvic floor, with resulting pain severe enough to prevent consummation of a relationship (sometimes for years). Soon anxiety comes to replace sexual enjoyment. Some patients can't even use a tampon; a vaginal exam may require anesthesia.

Nearly a third of women who have had gynecological surgery will experience some degree of pain with intercourse. Infections, scars, and pelvic inflammatory disease have also been reported as causes. Don't diagnose GPD when pain is only a symptom of another medical condition or is due to substance misuse. What percentage of women will qualify for GPD remains unknown.

Two examples of this somewhat clumsily named condition follow.

Essential Features of Genito-Pelvic Pain/Penetration Disorder

A patient has major, repeated pain or other problems with efforts at vaginal intercourse; she may experience anxiety, fear, or pelvic muscle tension.

The Fine Print

The D's: • Duration (6+ months) • Distress to the patient • Differential diagnosis (substance use and physical disorders, relationship problems)

Coding Notes

Specify:

{Lifelong}{Acquired}

Specify severity: {Mild}{Moderate}{Severe}

Mildred Frank

Mildred Frank and her twin sister, Maxine Whalen (see next vignette), had been having problems with pain during intercourse. Their symptoms were different and quite personal, but they had always discussed everything with each other. Now they had made the joint decision to seek help. The gynecologist had referred them both to the mental health clinic.

"It's sort of a burning," was how Mildred described her difficulty. "When it's bad, it feels like your hands do if you're sliding down a rope. It's awful! Even if I use Vaseline, it still bothers me."

The referral letter noted that she'd had surgery for a prolapsed uterus but was otherwise healthy. "I could have told you that," she said. "I've never even been to a doctor, except to have my babies."

On close questioning, Mildred admitted that the pain didn't occur often. But during the past year or two she had always been afraid it would hurt, and that made her invariably tense up when she was having intercourse with her husband. She'd had some vaginal infections, but these had been largely under control during the last few months; the gynecologist didn't think that they caused the pain she complained of. The letter also noted that her physical exam had been completed easily, with no evidence of vaginal spasm.

"Maybe I do overreact," she said. "At least that's what my husband tells me. He says I'm too excitable, that I should just relax."

Evaluation of Mildred Frank

Many women have **sporadic pain with intercourse**, in which case diagnosis is usually not warranted. But for a couple of years (criterion B) Mildred had experienced pain, tensing, and fear; each was enough to qualify her for the form of GPD that was once known as dyspareunia (A2, A4, A3). Her distress was evident (C); as ever, the real problem is to rule out other causes first.

Mildred described herself as otherwise healthy, and her gynecologist made no mention of other **medical problems**. Although she had had some vaginal infections, the doctor felt that they couldn't completely account for her pain. Her clinician would have to determine that there was no **substance-induced disorder**, though this would seem unlikely. Sexual dysfunctions can be expected with a number of mental conditions (**anxiety, mood, and psychotic disorders**), but her history supports none of them as a possible cause. Painful intercourse famously occurs in patients with **somatic symptom disorder**, but Mildred claimed that she was otherwise healthy, which would greatly reduce the likelihood of this diagnosis. All of the foregoing factors should lay to rest our concern about other causes (D).

Although Mildred's pain with intercourse was acquired fairly recently and only occurred occasionally, it did cause her to seek treatment. She had had no partners other than her husband, though nothing in the vignette suggests that she would have fared better with someone else. Although insufficient symptoms were noted to warrant a **personality disorder**, her clinician should note in the chart any behaviors that seem to justify further investigation. I'd give her GAF score as 71.

F52.6 [302.76]

Genito-pelvic pain/penetration disorder, acquired, mild to moderate

least one study has reported that, contrary to expectation, men with a pelvic pain syndrome experience minimal impact on their interpersonal relationships; indeed, pain levels and good relationship adjustment were directly proportional. Such a situation would obviate a diagnosis of GPD, even if DSM-5 had been disposed to allow it in a man.

Maxine Whalen

Maxine Whalen and her twin sister, Mildred Frank (see preceding vignette), had both been having problems with pain during intercourse; as noted above, they made a joint decision to seek help. Finding no anatomical causes for either of them, the gynecologist had referred both to the mental health clinic.

Maxine wasn't married yet, and she didn't think she wanted to be. "It's not that I don't get horny," she explained. "And I love foreplay. I could do it all night. But every time a man has tried to enter me, something inside me clamps down like a trap. I couldn't even get a pencil inside, let alone a penis. I can't even use a tampon."

Maxine usually relieved her frustration by masturbating, which reliably produced a climax. Oral sex had also worked. "Not many men are likely to be satisfied with that for long," she remarked. "It makes me feel like a freak."

The spasms that contracted Maxine's vaginal muscles produced severe, cramping pain. They were so extreme that her gynecologist had to insert the speculum under general anesthesia. The exam revealed no physical abnormalities.

On her second visit, Maxine remembered something that Mildred apparently hadn't known. When the girls were 4, they had been molested in some way. Even Maxine wasn't sure exactly what had happened. She only knew that some man—she thought it might be the Uncle Max for whom she had been named—had taken the girls to a tavern, stood them on the bar, and allowed the other patrons to "play" with them.

Evaluation of Maxine Whalen

Maxine's lifelong (criterion B) history of severe pain and obstructed penetration (A1, A2—only one required) suggests the diagnosis. The fact that the spasm was reproduced by the attempted introduction of the gynecologist's speculum was diagnostic. Unless a patient is both unattached and content to refrain from intercourse, it is axiomatic that vaginal spasms will produce distress or interpersonal difficulty (C).

Maxine's history did not indicate that there had ever been a time since she became sexually active when she was free of vaginal spasm (B); therefore, we'd call it lifelong. Her gynecologist found no physical cause (no surprise there, since none are usually reported—D). Her GAF score would be 65.

In DSM-IV-TR, Maxine's diagnosis would have been vaginismus.

F52.6 [302.76]

Genito-pelvic pain/penetration disorder, lifelong, generalized, severe

F52.31 [302.73] Female Orgasmic Disorder

Achieving climax is a problem for a lot of women, though studies have been persistently inconsistent as to just what that means. Perhaps 30% of women report significant difficulties; 10% never learn the trick. A few physical illnesses, including hypothyroidism, diabetes, and structural damage to the vagina, can contribute to the condition; if judged to be exclusively the cause, they obviate the diagnosis of female orgasmic disorder (FOD). Orgasm can also be inhibited by medications such as antihypertensives, central nervous system stimulants, tricyclic antidepressants, and monoamine oxidase inhibitors. Possible psychological factors include fear of pregnancy, hostility of the patient toward her partner, and feeling guilty about sex in general. Age, previous sexual experience, and the adequacy of foreplay must also be considered in diagnosing FOD.

women just don't complain of having premature orgasms, the way men do. Although it occurs (shown by surveys), it often doesn't pose a problem. Many women are able to enjoy sex without experiencing climax on a frequent basis. FOD is often comorbid with other sexual dysfunctions, especially female sexual interest/arousal disorder.

Essential Features of Female Orgasmic Disorder

A woman has been troubled by orgasms that are too slow, too rare, or too weak.

The Fine Print

For tips on identifying substance-related causation, see sidebar.

The D's: • Duration (6+ months) • Distress to the patient • Differential diagnosis (substance use and physical disorders, problems in partner relationship)

Coding Notes

Specify if: **Never experienced an orgasm under any situation**

Specify:

{Lifelong}{Acquired}

{Generalized}{Situational}

Specify severity: {Mild}{Moderate}{Severe}

Rachel Atkins

"I don't think anyone has quite the understanding of *frustrating* that I do," Rachel Atkins said to her gynecologist.

Her early history was "a sociological nightmare." She was born to a 16-year-old high school dropout who had gone on to a lifetime of serial marriages and alcoholism. Beginning when she was in middle school, a series of stepfathers had molested Rachel until, when *she* was 16, she'd bolted—into prostitution.

"How ironic is that, escaping from sex by going on the game?" she asked. But she was lucky enough to avoid AIDS and, when she was 22, smart enough to jump at a chance at college, financed by a conscience-stricken former client.

As a sex worker, Rachel had experienced hundreds of men. "It wasn't as bad as you might think," she explained. "I could pick my own johns, and some of them I rather liked—not at all like Mom's collection of rats." One possible victim of her experiences was her orgasm, which had always been missing in action. "I always figured it'd be there when I really wanted it. Only it never was."

Now a university graduate solidly planted in the academic world (she taught anthropology at a college in her community), Rachel was nearing 30 and had a boyfriend who wanted to marry her. "He knows all about my past, and he's OK with it. But he wants me to come when we have sex. I think it would reassure him that he's different from all those others. I desperately want to please him, but there's just something missing in me. It's beyond distressing!"

Rachel loved the closeness she felt with Henry, and she lubricated well. "I just never quite get over the top. It's like when you think you're going to sneeze, you know? And instead, it just dissolves in your nose." She'd tried mood music, alcohol, marijuana, erotic literature, and clitoral stimulation. "But I could be digging pottery shards, for all the good any of it does."

Apart from the usual teenage experimentation and the brief "therapeutic" flirtation with white wine and marijuana, Rachel had used no drugs. Her general health was excellent, she said.

"I promised Henry I'd always be truthful with him, and I intend to keep that promise. So I refuse to fake it. I could, though—I've sure had practice!"

Just why women have orgasms isn't actually known. Of course, the reason for the male counterpart is obvious: Its absence would leave us bereft of males *or* females. One of the more popular theories is that it developed in parallel with the male orgasm, and there's just been no evolutionary pressure for it to go away. The author of *that* theory must have been a guy.

Discussion of Rachel Atkins

Rachel's problem wasn't lack of interest in sex—she looked forward to it with her boyfriend, and she lubricated normally during foreplay. Her difficulty was solely her inability to climax—ever (criterion B). If she had had occasional orgasms, or if she climaxed only with masturbation, she could still receive this diagnosis, according to DSM-5's criterion A1; low intensity of orgasm would also qualify (A2). There was no evidence that **other medical** or **mental conditions** or **substance use** contributed in the slightest (D). What she did have in abundance was distress (C).

Because she'd never experienced a climax, we should add that verbiage to her diagnosis (which obviates the other possible specifiers). Her GAF score would be rated very high (95) for any patient, because of her overall excellent adjustment. I would rate the severity of her FOD as only moderate, largely because of the composure and well-balanced approach to her life she showed during the discussion with her clinician.

F52.31 [302.73]

Female orgasmic disorder, never experienced an orgasm under any situation, moderate

Substance/Medication-Induced Sexual Dysfunction

As with physical illness, a variety of psychoactive substances can affect the sexual abilities of men and women. Note that you would substitute the diagnosis of substance/medication-induced sexual dysfunction for a specific substance intoxication diagnosis only when the patient's problems in that area exceed those you would expect in the usual course of substance intoxication.

On average, perhaps half of patients taking antipsychotic and antidepressant drugs will report sexual side effects, though these will not always reach the level of clinical significance. Users of street drugs also often have sexual side effects, though they may complain less, since they may value their drug of choice more highly than sex.

The vast number of possible expressions has persuaded me not to include a vignette for this section.

Essential Features of Substance/Medication-Induced Sexual Dysfunction

Substance use appears to have caused sexual dysfunction.

The Fine Print

The D's: • Distress to the patient • Differential diagnosis (physical disorders, delirium, primary sexual disorders)

You'd only make this diagnosis when the symptoms are serious enough to warrant clinical attention *and* they are worse than you'd expect from ordinary intoxication or withdrawal.

Coding Notes

When writing down the diagnosis, use the exact substance in the title: For example, alcohol-induced sexual dysfunction.

ICD-9 kept coding simple: 292.89 for alcohol, 292.89 for all other substances. For coding in ICD-10, refer to Table 15.2 in Chapter 15.

Specify if:

With onset during {intoxication}{withdrawal}. This gets tacked on at the end of your string of words.

5 Psychiatric Interviews: Special Populations

Randon Welton and Jerald Kay

There is a popular image of the psychiatric interview where the patient and clinician sit comfortably in soft leather chairs in the psychiatrist's office surrounded by objets d'art and built-in bookshelves. The patient speaks clearly, honestly, and succinctly about his or her problem. The psychiatrist listens intently and understands thoroughly what is being said. This mutual understanding allows the therapy to begin effectively and proceed quickly to its successful conclusion. All too often, the reality of psychiatric practice reflects more challenging situations.

In this chapter, we shall be examining a number of special, but nonetheless common, clinical circumstances and patient populations that tend to bend the frame of the traditional psychiatric interview. There are an infinite number of special circumstances of course, and this chapter could hardly list, much less discuss, them all. Instead we will be looking at examples within two major themes. Sometimes the interview is extraordinary because of the circumstances surrounding the interview. At other times, psychiatrists will be interacting with a distinct population of patients; patients that inherently require an alteration of our approach. These situations require extra thoughtfulness and adaptation on the part of the clinician.

Included under the heading of *Special Circumstances* are patients located on *Inpatient Units*, on *Medical Wards*, or in the *Emergency Department (ED)*. The acuity of these patients and the lack of privacy in these locations contribute to the difficulty of the interview. Another set of special circumstances occurs in *Mass Casualty or Disaster* scenarios. In those calamities, the psychiatrist may be responsible to assess large numbers of patients in orthodox settings.

Even when the interview takes place in a more traditional setting, there are *Special Populations* that may challenge the psychiatrist. These include patients with severe *Psychotic Symptoms* or significant *Suicidality*. Interviewing *Children and Adolescents* can pose a challenge for the non-subspecialist. Also included in these special populations are those where there is a difference in language between the patient and the psychiatrist. This creates the need to incorporate *Interpreters* into the psychiatric interview. *Cultural*

The Psychiatric Interview: Evaluation and Diagnosis, First Edition. Allan Tasman, Jerald Kay and Robert J. Ursano.
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Barriers are invariably present with patients from different ethnic and racial backgrounds even when they are fluent in English. These differences add difficulty to the psychiatric interview. In these days of increasing demands and falling recruitment within psychiatry, *Telepsychiatry* is becoming an increasingly common solution to providing access to psychiatry. This new technology, however, often is accompanied by some unique issues that, if not addressed, add complexity to the clinical interview.

Psychiatric Interview in Special Circumstances

Special Circumstances — Inpatient Units

Interviewing hospitalized psychiatric patients is a routine responsibility that may lead to an insensitivity to the uniqueness of this environment. Because of the ubiquitous legal and financial demands inherent in inpatient treatment, modifications to interview style are necessary. Since a thorough history and physical examination must be documented within the first 24 hours of admission, this first encounter is likely to be the longest one-on-one interaction between the patient and psychiatrist.

This documentation of the history and physical examination must meet the standard required by regulatory agencies such as the Joint Commission for the Accreditation of Hospitals and includes, but is not limited to, assessments of the patient's preferred method of learning, patient strengths, risk to self, comprehensive psychiatric and medical history, and risk to others. Diagnoses and treatment plans are required as well. In addition, the psychiatrist will need enough information to satisfy utilization management and third-party standards for hospitalization. The time pressure to get the necessary information as quickly as possible shapes the psychiatrist's interview. In the rush to obtain the requisite information, clinicians often resort to simplified information-gathering tools such as checklists and "Yes/No" questions, which must be carefully balanced with the development of a doctor-patient relationship based on empathy and understanding.

Many inpatient units have adopted a team interview model where the psychiatrist is the collator of information rather than the collector of that information. These units see it as more cost-effective for nonphysicians to gather much of the background information. So rather than asking traditional open-ended questions about the patient's past experiences, the psychiatrist simply "signs off" on the history obtained by other mental health-care providers. This may limit the engagement in the therapeutic relationship between the patient and the psychiatrist.

The accuracy of a traditional psychiatric inpatient interview has been questioned. Researchers looked for inter-rater reliability among providers assessing 56 patients using three different methods. The methods included a traditional, unstructured diagnostic assessment (TDA), the Structured Clinical Interview for the DSM – Clinical version (SCID), and a Computer-Assisted Diagnostic Interview (CADI), which utilized questions based on DSM-IV algorithms. Following the individual interviews, the interviewers met to come up with a consensus diagnosis. Compared to the consensus diagnosis, the unstructured TDA was in agreement 53.8% of the time, considerably less than the structured approaches (SCID – 85.7%, CADI – 85.7%) (Miller *et al.*, 2001). The same facility then looked at agreement between the diagnosis in the ED and the ultimate diagnosis on the

inpatient unit. It used the same CADI to evaluate 39 patients in the ED and then reevaluated them on the inpatient unit with another provider using the CADI. This was compared to two groups who received TDAs in both the ED and the inpatient unit. The two TDA arms combined had 66 patients. Looking at inter-rater reliability found “poor” to “fair” agreement (45.5–54.5%) with the TDA, while using the CADI resulted in “excellent” agreement (79.5%) (Miller, 2001).

A final study by this group looked at the impact the assessment had on patient care. The use of the CADI ensured that the interview would cover all of the key criteria necessary to screen for the major DSM-IV criteria. Because it was preloaded with the DSM-IV algorithms, it would also cover all of the criteria when there had been a positive screening. The interviewer using a traditional diagnostic assessment on average asked only half of the key criteria screening questions and asked slightly less than half of the DSM criteria for the likely diagnoses. In these patients, who had been randomly assigned to the interviews based on their arrival at the hospital, the length of stay for those receiving the CADI was an average of 4.8 days less than those receiving the TDA (Miller, 2002). These studies did not address differences in long-term outcome nor the patients’ experiences in the various approaches.

The challenge for the inpatient psychiatrist then is to obtain the diagnostic accuracy of a structured or algorithmic interview while preserving the open-ended questions and empathic connection of the traditional approaches. Working on an inpatient unit requires the psychiatrist to perform a difficult balancing act. The pace, external accountability requirements, and diagnostic precision required for the inpatient admission will challenge a slower-paced traditional interview. Often relying on information provided by others and the use of more structured and less engaging interviewing techniques is attractive. The cost of this accommodation may be a decrease in the quality and significance of the relationships between the inpatient provider and his or her patients. Although no simple solution exists to this tension, the inpatient psychiatrist can utilize a few techniques to balance these positions:

- When possible, interview the patient after the other providers have collected their information. The psychiatrist can then refer to the information that others have obtained and ask the patient to expand on it. This demonstrates that the psychiatrist has some basic understanding of the patient but wants additional information.
 - *Example* – The previous interviewer recorded: Academic history – “Graduated High School in 13 years; a few classes at community college”. The psychiatrist asks: “I see that you needed an additional year to graduate high school and then went to college for a while. Tell me about that”.
- Continue to ask open-ended questions, especially at the beginning of the interview. Ignoring the patient’s perspective on why he or she was brought into the hospital can damage the development of a therapeutic alliance and limit the clinician’s understanding.
- Continue to make empathic statements rather than exclusively elicit symptoms.
 - *Example* – The patient has a chronic history of highly critical auditory hallucinations. “I see that you have heard voices for a long time and they say some pretty bad things about you. That must be horrible. How have you managed to deal with that for all of these years?”
- Aid in the development of a positive “institutional transference” by helping the patient build trust in the entire team and not just the psychiatrist. Utilizing and praising the

work done by the other team members can aid in this. Stress the ongoing communication among the team about the patient's particular situation and treatment plan. If possible, have them interact with multiple team members at a time along with the psychiatrist.

Summary of Recommendations

- Structured evaluations may be helpful.
- Do not neglect displays of empathy and opportunities to build rapport.
- Ask open-ended questions whenever possible.
- Purposefully develop a therapeutic alliance among the patient, the psychiatrist, and the rest of the team.

Special Circumstance – Medical Wards

Although the consulting psychiatrist first and foremost has the patient's best interest at heart, the principle reason for the consultation, nevertheless, is to assist the medical or surgical provider who initiated the consult. Depending on the culture of the hospital, these providers may be asking for the psychiatrist to take over the management of the patient's psychiatric issues while on the medical ward. In other facilities, the consulting psychiatrist is merely asked for advice on how to manage the patient and does not take an active treatment role.

The patient must understand the role of the consulting psychiatrist and that information obtained by the psychiatrist during an interview may be conveyed to the treating team. If this is not clarified from the outset, the psychiatrist can be placed in an awkward position of either knowing key elements of the patient's history that he or she does not relate to the treatment team request or of betraying the patient's confidence. There are often concerns about privacy. Although some patients will have single rooms and can be assessed in privacy, the consult on the medical ward often takes place in a room that is shared with at least one other patient. The patient's medical condition may make it impossible to move the consultation to a more private setting. These factors necessitate significant changes in the initial interview. Both the patient and psychiatrist must acknowledge and accept the lack of privacy and confidentiality as well as the dual agency of the consulting psychiatrist.

The medically ill patient presents some other significant challenges. These include gathering and understanding comprehensive details of the medical or surgical condition that necessitated hospitalization. The consultant psychiatrist often returns to reading textbooks or review articles. Drug–drug interactions in these patients may also be daunting. The psychiatrist must appreciate the psychiatric manifestations of unfamiliar medications and their interactions. Again, there must be a willingness to research these issues.

As part of the consult, the psychiatrist must routinely address behavioral medicine issues in addition to elucidating specific psychiatric diagnoses. Assessing the patient's psychosocial adjustment and how it impacts on the patient's health and response to treatment falls squarely into the consulting psychiatrist's purview.

- *Example* – A 55-year-old man was admitted to a medical ward on numerous occasions for uncontrolled hypertension. While on the unit his blood pressure was well controlled

with medications, within days of discharge his blood pressure rose dangerously. When asked, he insisted that he was taking his medication as prescribed and was following the other behavioral suggestions of the treatment regimen. The frustrated treatment team had asked for a consult to evaluate for malingering or factitious illness. The psychiatrist took an empathic, nonjudgmental approach with the patient, openly assuming that the patient was doing what he could to keep himself healthy. As the patient became more comfortable with the psychiatrist, this proud man disclosed that he did not have the financial resources to take his medication as prescribed and was in fact only able to afford to take the prescription “every three or four days”. The psychiatrist could then assume a liaison role to the team to help them negotiate the financial aspects of his care.

The lack of comfort with managing psychiatric illnesses on the medical ward goes both ways. Often the treatment team will be uncomfortable with the patient’s mental illness and have only a vague idea of what he or she would like the psychiatrist to do for him or her. This lack of clarity can be confusing for the patient and treatment team as well as for the psychiatrist. The treatment team may even consult mental health without informing the patients that they are doing so. When the psychiatrist shows up in the room, these patients can be surprised and sometimes offended that their providers have consulted mental health care without their knowledge.

There are some basic steps that the psychiatrist can take to improve the quality and value of the interview on a medical or surgical ward.

- *Specify the question to be answered* – As a consultant, the psychiatrist assists the medical team. The treatment team must, therefore, play a role in defining the focus of the psychiatrist’s interview. No matter how brilliant the information obtained and relayed by the psychiatrist is, if it does not answer the team’s question, then the consultation is not successful. Often the team does not fully understand what they want and will send a consult request that says in essence “See this patient”. In those situations, the consultant should talk first with the team to clarify what information would be the most helpful. Are they looking for help with diagnosis? Are they concerned about the patient’s current or proposed medication regimen? Do they have questions about the patient’s capacity to make informed decisions? Some authors have referred to this as the “center of gravity” for the consult. The psychiatrist assists the patient by helping the medical team understand what questions they have about the patient (Philbrick *et al.*, 2012). Frequently, the initial psychiatric consult may be inappropriate or impossible.
 - *Example* – “35-year-old recently diagnosed with cancer. Patient is crying. Please evaluate”.
 - *Example* – “54-year-old chronic alcoholic. He has failed numerous rehabs. He needs to stop drinking. Please assess and treat”.

One of the most important aspects of the consultation is helping the medical team understand and accept the limits of what psychiatric consultation can provide them and their patient (Nichita and Buckley, 2007; Perry and Viederman, 1981a).

- *Dealing with Skeptical Staff Members* – Unfortunately, the psychiatrist must occasionally deal with medical and surgical staff that neither understand the impact and importance of mental illness nor value the input of the psychiatrist. Often a psychiatry consult appears to team members as the most expedient way to relieve

themselves of a difficult patient. Explaining the limitations and value of a psychiatric interview and consultation can again be extremely helpful for the patient and the consulting team. The psychiatrist does not want to remove a patient's sadness over tragic events (e.g., the diagnosis of metastatic cancer). A brief consultation will not change chronic behavioral problems and cannot take the place of ongoing outpatient therapy. The consultant can, however, point the team in the right direction while recognizing that the bulk of the work must be completed elsewhere.

- *Lack of Confidentiality* – As the consulting team is the primary recipient of information, the psychiatrist must explain the limits of confidentiality to the patient at the beginning of the interview. The psychiatrist is there to help the medical team provide care. The information obtained may be conveyed to the team if it is important in the patient's medical care. The consult will be included in the general medical record and can be accessed by a host of personnel (Wise and Rundell, 2005). Of course, the consulting psychiatrist still has some discretion. Issues that might unduly embarrass the patient and will not directly impact patient care can usually be expressed in a tactful fashion.
 - *Example* – A 45-year-old female with metastatic breast cancer is being seen for depression. She discloses that her marriage recently ended when her husband announced that he was homosexual and left her for another man. The psychiatrist records: "Discussed the painful ending of her marriage".
- *Lack of Privacy* – When the interview takes place in a multi-bed room, the psychiatrist may pull the curtain shut for the illusion of privacy but his or her voice will easily carry to the other beds. If no private interview room is available or feasible, the patient can be positioned so that he or she is turned away from his or her roommate. The psychiatrist should speak softly but must ensure that the patient can hear and understand him or her. The lack of privacy should not prevent the psychiatrist from broaching potentially uncomfortable topics such as substance abuse and suicidality. Euphemisms and generalities can be used to start the conversation, but at some point the clinician will need to ask about them directly.
- *Distractions* – Although there is no way to prevent other medical personnel from interrupting the interview, nursing staff can be asked if there is anything they need from the patient before starting the interview. This should help minimize distractions. Politely insist that the television and other entertainment be turned off during the course of the interview.
- *Visitors* – Since some wards have restricted visiting hours and some visitors come from long distances, it often seems uncaring to simply ask them to leave. Working around the visitor's schedule is a kind and compassionate thing to do if possible. Those gestures can help create an instant therapeutic rapport with the patient. If, however, the psychiatrist lacks such flexibility, he or she can apologize to the patient and visitors and explain the need to interview the patient in private. Direct them to a nearby waiting room and be sure to notify them when the interview is finished.
- *Monitor Your Attitude* – Because the medical/surgical ward is often unfamiliar and uncomfortable to the psychiatrist, he or she can unconsciously adopt attitudes that are not therapeutic. Being surrounded by a "medical" environment, the psychiatrist might tend to function with a strictly biological focus. The psychiatrist adopting this unempathic stance directs his or her attention only to pertinent positive and negative

signs and symptoms, gathering much of the information from the medical records and staff members. This psychiatrist may stand by the bedside, simply confirming information already obtained from the record and adopt an attitude of the detached, benevolent authority. His or her recommendations would focus solely on laboratory studies and medication changes, ignoring psychological or social interventions. On the other hand, the psychiatrist, surrounded by poorly understood medical terminology, can overly identify with the patient. He or she can become enraged by perceived slights the patient has received from the staff and criticize the direction and pace of treatment even when he or she does not have a good understanding of the medical issues. The goal of the psychiatrist is to maintain a middle ground where he or she is more medically focused and interactive than in a traditional interview but still takes the time to let the patient explain his or her views (Perry and Viederman, 1981b).

- *Mental Status* – A significant number of psychiatry consultations center on the cognitive functioning of the patient. Up to 25% of consultations may be for some form of competency or capacity evaluation (Wise and Rundell, 2005). In addition, the psychiatrist is often asked to evaluate for confusion and/or delirium. Although the assessment of a patient's mental status may not always require the formal administration of a mental status examination, in these particular situations, the formal cognitive exam plays a pivotal role. Moreover, cognitive impairment may go undetected by nonpsychiatric medical personnel as well as by psychiatrists if there is not a deliberate exploration of those issues. The patient's social skills and polite conversation can compensate for cognitive impairment unless attention, concentration, memory, and executive functioning are specifically addressed. In order to assess cognitive functioning in a systematic way, it is advised that the psychiatrist utilize a standardized instrument such as the Folstein Mini-Mental Status Examination or the Montreal Cognitive Assessment (Wise and Rundell, 2005).
- *Collateral Information* – Especially when there is a component of cognitive impairment, patients may not be the best source of information about their current and recent life experiences and mental functioning. Even the most impaired patient deserves the psychiatrist's best effort at establishing rapport and utilizing the patient as the "expert on themselves", but the consultant must be prepared to contact family members or friends at times to clarify the patient's situation (Wise and Rundell, 2005). Although Health Information Portability and Accountability Act concerns are not raised when a sole psychiatrist gathers information, it is always best to gain the patient's consent before contacting outsiders. During these conversations with collateral sources, the psychiatrist needs to be aware that the thrust of questions may inadvertently convey personal health information to the other person. It is best therefore to stick to general questions: "What changes have you noticed in the patient?" "What other medical or mental health issues does he or she have?" "What medications does he or she take regularly?" Once the informant has brought up more focused problems such as depression, confusion, or hallucination, the psychiatrist should pursue those directly.
- *The Surprised Patient* – The psychiatrist should not be surprised that some patients will be unaware that the medical team has consulted mental health. This surprised patient can become resistant to the clinician. Hostility toward the consultant can arise through the misconception that the psychiatrist believes that the patient's problems are "all in his or

her head". For this reason, many psychiatrists insist that the team's consultation request be explained to the patient before the first visit. The psychiatrist can sometimes assuage the patient's hostility by emphasizing that understanding and addressing the psychosocial aspects of illness is an important aspect of the patient's overall medical care.

- *Example* – A 43-year-old female has been admitted for unexplained abdominal pain. The extensive workup has been negative. The consult request reads simply "43 y/o with abdominal pain without medical cause. Evaluate and treat". She is upset with her team's giving up on her and "calling in the shrink". "That's what they do when they can't find a cause. Rather than admit they are not that smart, they blame the patient". The psychiatrist explains that he or she has been invited to provide help to the team beyond the extensive workup that has been done. "Obviously your team believes you have pain or they would not have done those tests. Sometimes, though, the stress of chronic unexplained pain or persisting illness might make the person sicker than they were before. I'm wondering if you have noticed that your pain fluctuates with stress. Is it worse when things are going poorly and better when things go well?"

- *Complicated Medical/Surgical or Medication Issues* – Do not be afraid to acknowledge your ignorance. The psychiatrist can admit to the consulting team or even the patient that additional research must be conducted to better appreciate the clinical presentation. In addition to being honest, this interaction has other advantages. It models an active style of learning to the patient that he or she can use. Asking the consulting team for an explanation of the medical issues also sets a precedent for the psychiatrist explaining some of the behavioral health or mental health aspects of the case later on. Encouraging this type of interdisciplinary communication is an important aspect of the liaison function.

Summary of Recommendations

- Clarify the question.
- Clarify the roles and responsibilities.
- Engage with the consulting team.
- Address behavioral medicine issues.
- Strive for a private, uninterrupted interview.
- Complete the mental status examination.
- Maintain an empathic relationship.

Special Circumstance – Emergency Department

Interviewing patients in the ED combines many of the difficulties found on the inpatient unit and the medical ward. A significant number of patients presenting to the ED arrive with complex and severe psychiatric issues such as psychosis, suicidality, dangerousness to others, and/or aggressive behaviors. These issues are often compounded by medical illnesses and the misuse of psychoactive substances. The psychiatrist may be called to interview patients who are intoxicated or delirious. Many of these patients will be uninterested in receiving help and can be openly confrontational. There are also patients who present to the ED for what has been termed social reasons. They are homeless and know that reporting severe psychiatric symptoms is a path to shelter and meals.

The setting of the ED interview complicates a patient evaluation. The ED often lacks private, calming locations for the interview. The patient may be separated from other patients by only a sheet that does not reach the floor. Without accompanying records, the psychiatrist has nothing more than laboratory data, the physical examination, and his or her psychiatric interview on which to base his or her assessment. The evaluation may be further complicated by the ED's attitudes toward many psychiatric patients, especially when they are repeat visitors or so-called frequent flyers. These individuals are very familiar to the ED staff, and often "getting the patient up to the ward" is their sole priority.

As in the case of the Consult-Liaison psychiatry, an important aspect of treating this patient is determining the concerns of the ED staff. Often these concerns involve issues of dangerousness or the need for hospitalization. It is important that the psychiatrist knows not only what questions the ED staff have but also what prompted those concerns.

The psychiatrist should always look for past medical records. In addition to providing past diagnoses, these can also describe previous medication trials and offer a baseline of behavior and symptoms. If no such records are available, then the psychiatrist may need further discussion with ED staff members who likely have been observing the patient's affect, thinking, and behavior for several hours. Another potentially valuable and often overlooked resource are laboratory studies. The psychiatrist will want to know which have been ordered and which results have returned. Laboratory results may point to non-psychiatric issues that need to be addressed or provide reasons to delay the interview. For example, when patients are intoxicated, the psychiatrist will want to wait until the blood alcohol levels approach legal limits as information obtained while the patient is intoxicated is suspect at best.

Once again, the complexity of the situation, the acuity of the patient, and the inevitable time crunch will test the psychiatrist's ability to utilize an unstructured interview with open-ended questions. A more directed examination of the most pressing symptoms, pertinent risk factors, and criteria for admission may be indicated. Nevertheless, the patient's past psychiatric history, social history, substance use, and recent stresses must be elucidated. When suicide is a concern, in-depth exploration and documentation of current thoughts of death and suicide, recent violent or self-destructive behavior, a past history of violence or suicide attempts, current support systems, and substance abuse must be obtained (Feinstein and Plutchik, 1990).

Reliance on checklists of psychiatric symptoms is to be avoided since this practice does not permit the patient the freedom to tell his or her story in his or her own words and to express his or her understanding of his or her current predicament. While the interview will predominately focus on the presenting problem and acute issues, the psychiatrist should try to not immediately plunge into the heart of the crisis at the outset of the interview. A few questions about the patient's background and life circumstances demonstrate a thorough interest in the patient. This can also provide valuable insight into the patient's functional level as well as sources of social support.

In the rush to gather the information required for admission or medical/legal purposes, an opportunity for crisis intervention should not be squandered. Patients are exquisitely sensitive to perceived criticism and rejection by the ED staff, and a psychiatrist who is willing to make a concerted effort and take the time necessary to understand the situation can obtain valuable insights into the patient and can provide much needed

support for the patient. The psychiatrist in the ED will want to deliberately and rapidly develop a therapeutic alliance. An appreciation for the patient's past efforts at solving problems reassures the patient and helps to establish this rapport.

- **Example** – An unemployed 52-year-old man is brought into the Emergency Department by family concerned for his safety. He recounts numerous attempts to find work and his profound sense that he is failing his family. Being brought into the Emergency Department is humiliating proof of his failure. “Not only am I not helping them, but now they are having to watch over me like I am a child.” The psychiatrist praises his devotion to his family and his persistent efforts to find work. “Many people would have quit a long time ago, but I am getting the sense that quitting is not in your personality.” The psychiatrist then proposes that the patient work “just as diligently” with an outpatient therapist to get control of this depression. “The first, best step to get you back on your feet is to get this depression under control.”

Supporting patients and minimizing their distress while they are in the ED is not only practicing good medicine but can also facilitate the interview process. This could be something as simple as arranging for them to receive a blanket, glass of water, or medication to decrease acute anxiety. An attitude of reasonable optimism about the efficacy of medications and psychotherapy can help set the stage for future providers. All of these can elevate the ED experience from one where the psychiatrist is simply the gatekeeper to the inpatient wards to a critical therapeutic experience for the patient (Rosenberg, 1994).

Because interviewing patients in the ED is significantly different from what most psychiatrists do day to day, there are some steps that can increase the clinician's comfort during the interview and ultimately result in the provision of better care.

- **Feel safe and secure.**
 - If patients represent an imminent risk to themselves or others, arrange for support that is close at hand during the interview.
 - If the patient is acutely agitated, maintain a reasonable distance so that you are out of arm's reach, yet without being so distant as to make conversation difficult.
 - *Maximize Privacy* – Some EDs will have relatively quiet rooms that can be used for more difficult or sensitive interviews such as in the case of rape. If it is safe, ask for one of these rooms to increase the patient's sense of privacy and decrease distractions and interruptions.
 - *Speak to the Patient Alone* – The patient may have friends or family members with him or her. If the patient can speak for himself or herself, visitors should leave during the interview. This will decrease their opportunities to speak for the patient, and may help the patient speak more freely and accurately.
 - After the interview is complete, family or friends can be brought into the room or can be spoken to separately to confirm details of the patient's account or to gain outside perspectives. Unless the patient has expressly given permission, the psychiatrist should not provide information about the patient's condition.
 - Even with agitated and disorganized patients, it is worthwhile to start with open-ended questions. These will help the patient feel that he or she has been heard and understood. It also allows the psychiatrist to observe the patient's mental functioning in a naturalistic setting (MacKinnon *et al.*, 2006; Meyers and Stein, 2000).

Summary of Recommendations

- Clarify the question.
- Engage with the ED staff.
- Strive for a private, uninterrupted interview.
- Ask open-ended questions whenever possible.
- Build rapport.
- Maintain an empathic relationship.

Special Circumstance – Mass Casualty/Disaster Situations

One thumbnail definition of a medical disaster is when the available medical resources are overwhelmed by the demand. By definition then, there are more patients than can be dealt with using traditional care models. Strategies to evaluate large numbers of victims quickly have included the use of prognostic indicators such as elevated heart rate have had limited success (Ritchie *et al.*, 2006). Observation of current level of function and the psychiatric interview remain our most effective tools.

The psychiatrist in the mass casualty situation will quickly become overwhelmed if wedded to a rigid traditional psychiatric interview style. There are simply too many people who have been affected, too few providers, and too little time. Generally, in mass casualty settings, the psychiatrist is asked to do more than assess current symptoms. The clinician is also asked to predict risk for compromised future functioning. A further challenge is that the distress displayed by the patient in the immediate aftermath of the trauma may not correspond well with his or her previous and ultimate level of functioning.

The majority of people experiencing a trauma will exhibit only mild or transitory symptoms. The rate of posttraumatic stress disorder (PTSD) following a traumatic event is highly variable. Rates as low as 10% can be found in the victims of accidents, while 46% of women and 65% of men who have been raped will meet criteria for PTSD (Kessler *et al.*, 1995). Although PTSD is intimately associated with disasters, it is not the only psychiatric disorder seen after a trauma. A significant number of people will develop depressive or anxiety symptoms, but most people will ultimately do well following the trauma (Ursano *et al.*, 1995).

A complicating factor during the posttrauma interview is that it may occur in a variety of nontraditional settings such as homes, shelters, and temporary facilities. One common strategy among military mental health providers is to triage by walking around, the idea being that it is more helpful to interview victims in their own environment than to wait until they venture into the mental health services area. This walking triage may be especially important as at-risk populations include more than just the identified victims of trauma. The psychiatrist in a mass casualty situation should also attend to the distress and functioning of coworkers. They are often the victims of secondary traumatization and provider fatigue. Depending on the size and location of the disaster, the psychiatrist too might have been personally affected. If the clinician has missing friends or relatives or has potentially lost his or her home, his or her ability to evaluate patients might be impacted (Ritchie and Hamilton, 2004).

The interview will be further complicated by the patient's complex and shifting response to the recent trauma. He or she may have intense and mixed emotions regarding the event. There will of course be grief and loss. He or she may also be afraid to remember details of the event. Often there is tremendous anger directed toward people whom he or she holds responsible for the trauma or for a lack of a prompt effective response to the trauma. Guilt about behavior during or after the event is common. He or she may feel that his or her response was inadequate. There also might be guilt about having survived when others did not. All of these make it difficult for casualty survivors to openly discuss the event with the psychiatrist (Connor *et al.*, 2006).

Cultural considerations are always important during the assessment following trauma. Allowing mental health providers of different cultural backgrounds to assist in the aftermath of a trauma may be met with resistance. Since culture may alter how patients express their symptoms, overreliance on DSM phenomenology may be unhelpful. For example, it has been noted following traumas in Japan that the Japanese may be reluctant to acknowledge "depression" even when they meet criteria for it (Connor *et al.*, 2006). In many rural settings, personal identity is bound inextricably to religious identity. Also, a deep attachment to a village may intensify the sense of loss even when personal, household loss has not occurred. All of these cultural factors may impact how the trauma is experienced by the individual (Bryant and Njenga, 2006).

Guidelines for interviewing the victims of mass casualty situations include:

- Look for life-threatening physical conditions. These must be addressed immediately.
- Assess mental status and level of consciousness as these may be indicators of physical injuries or worsening medical conditions.
- Be aware of your appearance and presentation. The psychiatrist will inevitably be seen as an outsider but needs to dress in a fashion that will promote acceptance as a benevolent authority figure by the injured population (Ritchie and Hamilton, 2004).
- Educate survivors regarding normal cognitive, emotional, behavioral, and physical changes following trauma. Highlight that these are common responses to abnormal situations and will likely resolve without specific interventions. Emphasize that these symptoms are not inherently dangerous or an indication of moral or mental weakness.
 - Common impairment includes:
 - *Cognitive* – Memory loss, anomia, impaired decision-making, poor concentration
 - *Emotional* – Anxiety, grief, irritability, feeling overwhelmed, fear of future loss
 - *Behavioral* – Insomnia, hypervigilance, crying, ritualistic behaviors
 - *Physical* – Fatigue, nausea, tremor, motor tics, dizziness, gastrointestinal distress (Flynn and Norwood, 2004; Ritchie *et al.*, 2006; Ursano *et al.*, 2003)
- Watch for symptoms of extreme avoidance, numbing, or dissociations. The presence of dissociations in particular has been associated with an increased risk of PTSD (Ursano *et al.*, 2003).
- *Ask the Victims about the Meaning of the Disaster* – The trauma frequently threatens more than the individual's life, family, or livelihood. Often these events will challenge the victims' understanding of how the world functions. Individuals living with a "just world hypothesis", where good things happen to good people and bad things happen to bad people may find that point of view inadequate to explain what they have just experienced. Others will have their core religious and spiritual beliefs challenged in a way that it had not been challenged before.

- *The Use of Screening Tools* – There is some controversy as to the utility of screening tools, with some authors finding it a useful means to getting information on people quickly and others doubting the reliability of the information obtained (Connor *et al.*, 2006; Ritchie and Hamilton, 2004).
- *Emphasize Strength, Resilience, and Growth* – While the psychiatrist should not minimize the destruction and distress caused by the disaster, it is also important to recognize that these traumatic events are often a time for growth. Individuals will demonstrate strength and coping abilities that they may not have realized that they had. Communities will often pull together and support each other. This growth may not be evident during the initial interview, but the psychiatrist can lay the groundwork for recognizing it by inquiring about it even in the early stages of the post-disaster period.

Summary of Recommendations

- Be prepared to leave the clinic and interview victims where they are.
- Discuss common emotional, physical, and behavioral responses to trauma.
- Watch for cultural differences in responding to trauma.
- Emphasize strength and resilience.

Psychiatric Interview in Special Patient Populations

Even when the psychiatric interview takes place in the comfort of the psychiatrist's office, there can be groups of people who raise special challenges. In general, these are patients whose baseline functioning or illness inherently complicate the interview process. Often adopting a different style or using different questions to elicit data is vital.

Special Populations – Patients with Psychosis

Psychotic symptoms can be divided into those which affect the content of thought and those which alter the flow or form of thought processes. Although routine for psychiatrists, each of these categories presents separate problems for the interviewer. Problems with thought content include delusions, thought blocking, thought insertion, and perceptual abnormalities such as hallucinations. These experiences, which diverge greatly from common experience, make it difficult for these patients to express what is going on in their lives. They may have difficulty putting their fears or belief systems into words. They may have difficulty differentiating events in their lives from internal experiences, which appear to be just as real. Formal thought disorders result in communication that is difficult to follow. Because of loosened associations or incomplete ideas, the interviewer may have trouble getting a coherent story. The interviewer's challenge is to overcome these obstacles and get as much useful information as can be obtained within a reasonable period of time.

Often seriously impaired patients have a long history of psychiatric illness. The psychiatrist during the initial interview should inquire about past interactions with mental health providers. "What should I know about your illness?" "How can I help you?" "What

has worked in the past?” “What have other providers tried that did not work?” These past experiences can shape the current interaction (MacKinnon *et al.*, 2006). Positive interactions should be highlighted as evidence of the help that psychiatry can offer. Negative experiences can be acknowledged, followed closely by a description of how this encounter can be different.

There are some strategies that apply to patients with both types of psychotic symptoms. These patients have often been brought for evaluation by someone else and therefore might get frustrated because they are in the hospital. The psychiatrist can sympathize with their resentment during the interview but also note their desire to help the patient. Psychotic symptoms often create a gap between the experience of the patient and of anyone trying to communicate with him or her. This makes it harder to generate empathy for the patient and leaves the provider more likely to do a perfunctory assessment (MacKinnon *et al.*, 2006). To help bridge the gap, the psychiatrist should ask about the symptoms that bother the patient. Perhaps he or she is not bothered by the voices that he or she hears but is upset at feeling constantly tired. Other common complaints might include anxiety, pain, nausea, or problems with sadness. By focusing initially on these symptoms, the provider might be able to bridge some of the gap separating the patient's world from his or her own (Shea, 1988).

- *Example* – A 28-year-old man with a history of schizophrenia is brought into the ED after he was found wandering in a city park by the police. He perseverates on comments such as “I shouldn’t be here. I need to go”. The psychiatrist perceiving this agitation says: “Some people were pretty concerned that you were getting confused. They have asked me to see if I can help figure out what is going on. You look pretty worried. Is there anything I can help with?”
- *Psychotic Thought Content* – Often the patient is terrified and confused by what he or she is experiencing and might have no reason to believe that the psychiatrist can be of any help. Although the psychiatrist’s ability to empathically enter the patient’s world can be limited, a therapeutic alliance must be forged (e.g., “Can you help me understand what is upsetting you?”). As is true in any patient encounter, the psychiatrist uses his or her emotional response to what the patient is describing as an important vehicle to enhance communication. Attentiveness to a patient’s emotional state can help focus the patient and develop rapport (MacKinnon *et al.*, 2006). There is a need to look for any topic that appears to carry a significant emotional valence since this displays interest in the patient and facilitates clarification of his or her inner experience. With expressions of fear comes the opportunity to offer realistic but consistent hopefulness while emphasizing the current level of safety (Shea, 1988).
 - *Example* – A disheveled 34-year-old woman, Alice, is brought into the ED by the police. She had been arrested running down the street striking cars with a rock. She appears terrified in the ED and is curled into a near fetal position without acknowledging the psychiatrist when he enters. “Alice, you look very upset. Can you tell me what is going on”. Alice responds: “I can’t take it anymore”. She is no longer sure who is harassing her. She figured that by striking the cars she would draw out the assassins who were following her. “Alice, it must be terrible to feel that frightened all of the time. Do you feel safe in here?”

With these few simple sentences, the psychiatrist has made an effort to establish an empathic connection. Demonstrating sympathy for her troubles, the clinician has also addressed her with respect and dignity. These can be the first steps toward developing a meaningful therapeutic rapport.

With a patient who focuses on a single issue, such as a systematic delusion, the psychiatrist will emphasize the need to gain understanding into other aspects of the patient's life. This type of patient will often lose the point of open-ended questions and shift the topic back to the thought that consumes him or her. To get useful information in this case, the psychiatrist will have to shift from open-ended questions to more direct questions. Sometimes these will have to be questions that can be answered by a "yes" or "no".

As in any patient encounter, honesty is vital. Attempts to enhance the therapeutic relationship through misinformation (pretending to see or hear his or her hallucinations or acknowledging conspiracies) are prone to failure. Once the patient realizes that the psychiatrist has not been truthful, the therapeutic alliance is almost certainly damaged, sometimes beyond repair. It is usually possible to accept the patient's response to his or her experiences without agreeing to his or her perception. "I know that you are hearing an evil threatening voice, but I do not hear it and no one else here is hearing it. I think that voice is coming from within your mind".

Other specific advice includes:

- *Delusions* – Realize that you will not be able to convince the patient to abandon his or her delusions, and that he or she will refuse to accept facts that you hold to be incontrovertible. Acknowledge that he or she believes what he or she is telling you and that he or she believes there is abundant evidence supporting him or her. Do not hesitate, however, to wonder with him or her if there might be some other way to explain the facts. The psychiatrist can acknowledge the anxiety and frustration the patient experiences in trying to convince others to believe something that they know to be true (MacKinnon *et al.*, 2006).
- *Paranoia* – Interviewing the paranoid patient is one of the most difficult challenges for the psychiatrist. This patient will mistrust motives from the start. He or she will present himself or herself in a guarded fashion based on his or her fear that what he or she says will be used to hurt him or her. Tactful telling of the truth in these situations may not win the patient over but is still the psychiatrist's best option. Acknowledge that he or she is not free to leave when he or she wants and that your evaluation will play a role in what happens to him or her. "You might disagree, but I think the people who brought you here are truly concerned for your safety. They want me to help determine if you are safe". Avoid humor with these patients. They are unlikely to enjoy it and can easily assume that you are making fun of them, thereby increasing their agitation. The psychiatrist will often agree with the facts that the patient presents without agreeing with his or her interpretation of those facts. "I believe that you saw five black cars pass by your house. I am just not sure that means that the CIA has you under surveillance". Resist the patient's attempt to pull you into a power struggle. The goal is to assess his or her functioning and safety, not to debate with him or her. Regardless of good intentions and efforts, the patient may be suspicious of the psychiatrist or even contemptuous. Accept his or her need for emotional distance and psychological defenses while proceeding with the interview (MacKinnon *et al.*, 2006).

- *Hallucinations* – The voices that the patient hears and the things that he or she sees are just as real to him or her as you are. Therefore, attempts to dismiss them or minimize their importance will rarely succeed. Instead, ask about them as you would about any other experience (Shea, 1988). You can ask for details such as:
 - How many voices are you hearing?
 - What are they saying?
 - What can you tell me about them?
 - Do they remind you of anyone you know?
 - Are they talking with you now?
 - How difficult is it for you to pay attention to me with them talking?
- *Formal Thought Disorder* – These patients are attempting to express themselves but are unable to do so in a fashion that can be followed by the psychiatrist. The psychiatrist will usually pick up on this within the first few minutes of conversation. Readily, but tactfully, admit to difficulty understanding what the patient is trying to say. This can usually be done without humiliating or blaming the patient. The psychiatrist might find open-ended questioning as being unproductive. Attempts to gain information through direct questioning should nevertheless include reflections on the patient's spontaneous speech and topics of conversation. This presents the best opportunity for making an empathic connection with the patient.
- *Example* – A 45-year-old man with psychotic mania has extremely loosened associations. His rambling digressions include his involvement with both the president and the governor and their plans for him to assist them personally on special projects. As he is completing the interview, the psychiatrist comments: "I know I have not heard about everything that is going on in your life, but listening to you for these few minutes I am struck by the sense that you have a lot of potential and opportunities, but are not quite sure what you want from your life".

Summary of Recommendations

- Ask about past interactions with mental health.
- Show empathy for their distress.
- Acknowledge their perceptions without necessarily agreeing with their conclusions.
- Do not debate with them.

Special Populations – Suicidal Patients

Patients with a significant risk of suicide are an extremely common cause of emergent psychiatric consultations. The psychiatrist often enters the situation with little to no previous alliance with the patient. In order to obtain useful and truthful information, the psychiatrist must quickly establish a working rapport. Since suicidality is the reason for the consult, there is a temptation to jump immediately into a discussion of that issue. The patient, however, has little motivation to be honest with a provider he or she is just meeting. If he or she is truly suicidal, he or she will see it in his or her best interest to be deceptive. If he or she is not suicidal, he or she will either tell the truth, which might

make it difficult to distinguish him or her from the deceitful suicidal patient, or he or she might try to deceive the provider for other reasons such as an attempt to gain admission to the hospital.

The best strategy for the psychiatrist is to spend some time getting to know the patient broadly before broaching the topic of suicidality. This discussion will help build rapport but will also start filling in the suicide risk factors that are central to the assessment.

- What has brought them into the hospital?
- What do they think can be done to help them?
- Ask about their recent stresses: What has changed in your life recently?
- Ask about recent neurovegetative symptoms.
- Ask about their past psychiatric history: Have they ever been admitted for psychiatric reasons? Have they ever been treated as an outpatient?
- Are they currently under the care of a mental health professional?
- Ask about their social support.

After gathering this background information, the psychiatrist can move onto more direct questions. Normalizing thoughts of death and suicide is often an effective means of starting the exploration of those issues, e.g., “Many people in your situation would have thoughts of death. They might wish they were dead or have thoughts about killing themselves. Have you had thoughts like those?”

The psychiatrist will need to ask about suicidality directly.

- *Suicidal Ideation* – How frequent are the thoughts of killing themselves? How long have they been present? Are they changing in intensity or frequency?
- *Suicidal Plan* – Do they have a specific plan to end their life? Is it realistic? Is it lethal? Are they likely to be rescued in the attempt?
- *Suicidal Intent* – Do they want to die? Do they feel it is inevitable that they will die?
- *Preparation and Rehearsal for Suicide* – Have they obtained lethal means? Have they practiced the suicide attempt?
- *Suicide Attempts* – Have they ever tried to kill themselves in the past? Do they have family or friends who have committed suicide?
- *Protective Factors* – We should also ask about what has kept them alive to this point.

The risk assessment, however, includes more than just questions asked to the patient. The interviewer’s observational skills are also necessary. What is the patient’s affect? Does he or she maintain good eye contact? Does he or she display psychomotor retardation? Is there significant anxiety or agitation?

Gathering this information is only the first part of the suicide risk assessment. Once the information has been gathered, the clinician should consider the patient’s acute and chronic risk of suicide. It might be helpful to divide these risk factors into several categories: static risk factors, dynamic risk factors, and warning signs.

- Static risk factors for suicide are often demographic information that cannot be quickly altered.
 - *Male Sex* – Men are three to four times more likely to commit suicide.
 - *Age* – Although there are legitimate concerns about suicide in young adults, in general the rate of population is highest among the oldest individuals.

- *Race* – Elevated rates of suicide are found in White and Native Americans than in Black and Hispanic Americans.
- Family history of suicide.
- *Prior Suicide Attempts* – This is perhaps the most robust risk factor. Approximately 10–15% of those who have attempted suicide will ultimately kill themselves.
- *Being Single* – Although it is not found in every study, being divorced, widowed, or never married seems to increase the risk of suicide.
- Dynamic risk factors for suicide are ones that can be changed through intervention.
 - Untreated mental illness.
 - *Emotional Turmoil* – This can be brought on by recent financial or legal problems, acute and chronic medical conditions, or relationship issues.
 - Expressed suicidality.
 - Access to weapons and other lethal means.
- Warning signs are indicators that suicide may be imminent and are further divided into two tiers. Both of these groups still indicate marked elevation of risk but the second is more concerning.
 - Warning signs include hopelessness, rage, anger, acting recklessly, feeling trapped, increasing alcohol or drug use, withdrawal from friends, anxiety, agitation, altered sleep, dramatic changes in mood, and seeing no reason for living.
 - Imminent warning signs include direct threats to harm themselves, searching for means to kill themselves, and writing or talking about death and dying.

The key for thorough suicide risk assessment and management is to incorporate all of the elicited information and then generate a comprehensive plan based on it. The plan should minimize as many dynamic factors and warning signs as possible while enhancing the protective factors. This should be done in a biopsychosocial manner. Biologic interventions can include starting antidepressants, realizing that these may take several weeks to take effect and might even increase agitation in the short term. If insomnia has been a significant factor, then the psychiatrist can consider safe methods for assisting sleep. Psychological interventions should include the initiation of psychotherapy, which can be facilitated during the initial interview by delineating some of the major conflicts that are upsetting the patient. Social interactions can include increasing support as well as helping to create a safer environment for the patient. Environmental manipulation can include reducing access to lethal means of self-harm. Often with the patient's permission, family and friends can be involved in controlling access to potentially dangerous weapons and medications. Social manipulation might also involve hospitalization as a means of protecting the patient while waiting for the other interventions to have an opportunity to work (Welton, 2007). Providers can never completely prevent suicide in patients who have committed themselves to dying, but a thorough evaluation and appropriate intervention is the best method for helping these patients.

Summary of Recommendations

- Work to establish rapport.
- Be aware of and inquire about suicide risk factors.
- Ask about protective factors.
- Biopsychosocial interventions should target dynamic risk factors and warning signs.

Special Populations – Children/Adolescents

Alterations in interview style and content must be expected when working with children and adolescents. Even within this group, there is great variation depending on the age and maturational level of the child and the circumstances leading to the interview. The interview of a depressed or traumatized 5-year-old will be very different than the interview of a depressed or traumatized 9-year-old.

Adults will usually enter a psychiatrist's office with some idea of the role and capabilities of a psychiatrist. The child may not have this understanding and may find the experience extremely foreign and threatening. Helping to clarify children's expectation about the interview and their perspective on the issues that brought them in to be assessed is a good starting point. Especially with younger children, it is helpful to clarify that they are not in trouble and have not been brought in because they are bad (Sadock and Sadock, 2003).

The psychiatrist might want to start the interview with a review of the less charged aspects of the child's life such as involvement in hobbies, sports, and favorite leisure time activities. These topics also provide useful information about the number and quality of his or her interactions and social, academic, and physical development (Sadock and Sadock, 2003). Younger, school-age children can be brought into a room with a variety of toys and observed in unstructured play. As the child plays, the interviewer can ask questions about the child's inner life. Having toys that are reminiscent of home situations (e.g., adult and child dolls) can also lead to fruitful discussions about relationships with the child, inevitably conveying information about his or her home life. Another useful technique is to ask the child to draw. Asking children to draw family members and having them talk about their families can also establish their views on family dynamics. The interviewer looks for themes or patterns in the child's play and drawings. There are still questions that need to be asked, but the psychiatrist will likely need to modify the questions. Open-ended questions may be less successful than giving the child several possible answers. The interviewer can still try an open-ended question but have a list of possible answers if the child cannot answer (Sadock and Sadock, 2003).

- *Example* – During an interview the child is asked, "How have you been feeling?" She answers, "Good I guess". The interviewer goes on, "Have you been feeling sad or angry or scared?"

Some of the differences in interview technique are straightforward and require sensitivity to developmentally appropriate language. The simple question "Are you depressed" may have no meaning to a bright 8-year-old, or even worse, may mean something completely different than what the clinician intended. Often simple behavioral or functional questions can be substituted for more complex or abstract ones. Rather than asking about lethargy, anhedonia, appetite, and anxiety, the interviewer can ask questions such as: "Do you get tired easier than your friends?", "What do you do with your friends that is really fun?", "Do you eat everything on your plate at meals?", or "Is there anything that is scaring you?" In addition to ascertaining the DSMIV-TR criteria for mental illness, the interviewer working with small children should also attempt to obtain an understanding of their level of development. This will help guide future interventions if deficits are found.

One model used to understand the development of younger children is the Developmental, Individual difference, Relationship (DIR) model. This model seeks to facilitate a comprehensive understanding of the child through a systematic evaluation of three major components of his or her mental life. The interviewer examines the functional emotional development of the child, the sensory reactivity/cognitive processing/executive functioning of the child, and finally the relationships the child has with significant caregivers in his or her life.

- *Functional Emotional Development* – The first category involves the child's ability to work toward emotionally meaningful goals. This will be evaluated by looking at a variety of responses and behaviors:
 - Is the child able to retain a sense of calm while watching and listening to his or her caregivers?
 - Does the child display apparent pleasure from his or her interactions with his or her caregiver?
 - Does the child engage in reciprocal communication with the others?
 - Can the child engage in problem-solving communication?
 - Can the child engage in creative and imaginative play?
 - Can the child give meaning to symbols?
 - Can the child display the ability to use logic, reality testing, and judgment in interactions with others?
- Sensory reactivity, cognitive processing, and executive functioning are also assessed. This category recognizes the fact that even children who have significant similarities in their emotional development may have significant differences in their cognitive function. These variations can be the result of genetic, prenatal, or maturational factors. The areas to be evaluated include:
 - Reactivity to sensory perception
 - Does the child underreact or overreact to sensory stimuli?
 - Sensory processing
 - Is the child able to register, decode, and comprehend what he or she is hearing and seeing?
 - Ability to process and react to affect with action or communication
 - Does the child understand emotional responses and act accordingly?
 - Ability to plan behavior and predict consequences of behavior
- Assessing the style and quality of relationships
 - Does the child have appropriate interactions with primary caregivers and family members?
 - How does the child choose to engage with his or her environment? Does he or she seek out interactions with those around him or her? Does he or she explore his or her surroundings appropriately?

The DIR model leads to an individualized profile of the child that can serve as a basis for developing targeted interventions. It considers biological and psychological development as well as valuing the social interactions as a significant factor in child growth (Greenspan and Wieder, 2003).

A one-on-one interview of the child is rarely sufficient to develop a complete understanding of his or her world and mental state. Children often lack the self-observing

functions necessary to describe themselves in an objective fashion. The younger the child, the fewer his or her reference points for normal behavior. Because of these factors, collateral information is vital. Parents or other primary caretakers can provide the best overview of the child and can provide key insights into the developmental history. In addition to augmenting the child's perspective, these caregivers can discuss neurovegetative symptoms such as eating and sleeping habits as well as describe interactions with others (family and friends). If possible, both parents should be interviewed. This will sometimes help provide a more balanced perspective as well as clarifying the differing expectations, perceptions, and roles that exist within the family.

In addition to family information, with school-age children, information from teachers and counselors can be extremely important. The classroom represents a ready-made control group where the child's performance and behavior can be directly compared to those of peers. Parents may at times have a very skewed view of their child based on their personal expectations and what they see at home. Experienced teachers and school counselors often have a more accurate view of the child's functioning in structured and controlled settings.

As the interview proceeds, the issue of confidentiality can be introduced. Confidentiality will depend largely on the age and developmental stage of the child. With very young children, there will be very little that will be held back from the parents. As the child ages, he or she will have more right to maintain some information from his or her parents (Sadock and Sadock, 2003).

Often parents wish to be present when the psychiatrist talks with their child. Children may also find the doctor's office an intimidating place and wish strongly that their parents stay with them. In both of these instances, the interviewer should politely push to be alone with the child for at least part of the interview. One common strategy is to speak with the child and parents at first. This gives the parents and child an opportunity to help define the problem. It is also a helpful time to ask about past treatment, past similar experiences, and trends in symptoms. Hopefully, by this time, both the child and parents are feeling more comfortable with the psychiatrist, who can then outline the rest of the interview process. After speaking to the parents and child, most psychiatrists will prefer to speak privately with the child. This will be followed by interviewing the parents and then bringing everyone back into the room.

Interviewing the child without his or her parents provides several advantages. In addition to increasing disclosure from the child, it allows the interviewer greater freedom to conduct the interview without having to explain interview techniques or involve the parents in the conversation. It also keeps the parents from answering for their child and solidifies the relationship with the child. Speaking to the parents alone similarly helps them to reveal information about the child and their home life that they may not feel comfortable expressing in front of the child. Finally, bringing everyone back into the room for a few minutes will allow the psychiatrist some additional insight into the family's functioning. How does the child interact with his or her parents? Does he or she turn to the parents as a source of support? Is he or she dependent on the parents to speak for him or her? How does the child's interaction with the psychiatrist change when his or her parents come back into the room? Bringing the family back together also allows the psychiatrist to ensure that all know what the treatment plan includes and what the next step will be.

Adolescent Issues – During the interview of adolescents, the psychiatrist must remember that their inner world and experiences might be much broader than their parents

realize, and, therefore, nothing can be assumed. The interviewer must ask teenagers about their sexual experiences, alcohol consumption, and recreational drug use. If these experiences are normalized, there is a greater chance of getting truthful information from the adolescent, e.g., "Many teens your age have already had sexual experiences. What experiences have you had?" As teens may feel uncomfortable answering these issues in front of their parents, interviewing them separately is crucial. They may still be hesitant to answer questions if confidentiality has not already been discussed.

The interview of a minor carries with it legal as well as ethical obligations to ensure the safety of the child. This can include inquiring about abuse or neglect as well as asking questions about violence at school, in the neighborhood, and at home. Particular interest should be paid to the issue of punishment for misbehavior. Most states will have a requirement that a reasonable suspicion of abuse must be reported to state agencies for further evaluation.

Summary of Recommendations

- Clarify interview process with child and parents.
- Inquire about all aspects of child's life.
- Interview child and parents alone and together.
- Consider developmental issues.
- Discuss confidentiality.

Special Populations – Using Interpreters

An increasingly common situation is when the patient and psychiatrist are separated by language. Subtleties of speech and nonverbal communication are central in understanding patients. Differences in language between the patient and interviewer can obfuscate those vital clues. Even slight problems with fluency can have a significant impact. Studies have found that psychoanalysis conducted with bilingual people is more successful in their first language than in their second (Farooq and Fear, 2003). Most facilities have made some accommodations for dealing with patients who do not speak English, but working with these interpreters does not eliminate all of the challenges. There are several categories of interpreters that might be used. These include family members or friends, bilingual hospital personnel, or outside volunteers/contractors. Each category has potential risks and benefits.

Family/Friends

One of the primary advantages to using family is availability. Often they will already be nearby when the psychiatrist arrives. Becoming interpreters provides them an opportunity to directly help the patient. Their involvement also contributes to the patient's support of the treatment plan since very meaningful people have been involved in the discussion. Another advantage is that family and friends may have a wealth of knowledge about the patient's biopsychosocial history. Often they are familiar with the patient's medical history and current medications. They can provide instant collateral information. If the patient is being unclear, evasive, or deceitful, they may share this observation with the

clinician. They can also comment on changes that they have seen in the patient over time. The psychiatrist can ask if the patient is expressing himself or herself as he or she normally does. "Does he or she sound confused or appear nervous or sad?" Despite the advantages of using family and friends, however, the disadvantages may be even greater.

If the psychiatrist does not know the patient, then he or she probably does not know the family either. The interviewer will be unaware of who in the family knows the patient well and who will be the most truthful. There is a temptation for the family member to change the story to protect the good name of the family through excluding or minimizing embarrassing information as he or she translates (Phelan and Parkman, 1995). Family members may have preconceived ideas about the patient's condition. They can steer the psychiatrist in a way to cast blame on who or what they think is responsible for the patient's distress. Family members without medical training or background may not understand the questions that the interviewer is asking, but may be hesitant to ask for clarification. On the other hand, they may not understand the patient's response and rather than report the patient's distorted information, they may insert their own answer to the question. They, of course, might be providing accurate information, but at this stage in the assessment, the interviewer needs to hear the patient's responses in an unadulterated form. There is also no control over the quality and nature of the relationship that the patient has with the family members. Perhaps the family member who is volunteering to translate is being abusive or neglectful toward the patient, and this may not be clear during the interview. Ideally, family members should provide a calming experience for the patient, yet often the closest relationships can be the most provocative. This can lead to increased agitation during the interview. Family members may be more likely than other interpreters to insert their own questions and openly disagree with the patient's answers to questions (Phelan and Parkman, 1995). Privacy is also a significant concern since the patient is asked to disclose highly personal information in front of individuals with whom he or she is likely to interact throughout his or her lifetime.

Bilingual Staff

Many psychiatrists prefer to rely on their bilingual staff members, especially if these are mental health workers. These individuals will be knowledgeable about their role as interpreters. Appreciating colloquialisms and common expressions facilitates the interviewer's intentions and meanings in ways that are preferable to a literal word-for-word translation. The patient may be relieved to have a staff member with whom he or she can talk freely and will often turn to them for support. This supportive presence may encourage the patient to be more honest and disclosing. Because these interpreters are trained medical personnel, the interviewer is often more comfortable in inquiring into sensitive issues. Questions about drug and alcohol use, sexual tendencies, and infidelities may be difficult to ask when using a family interpreter, but will be significantly easier when the interpreter is a medical professional.

These trained staff members can describe basic mental functions such as thought processes and thought content. "Does the patient ramble?", "Is the patient answering questions logically?", and "Is he or she paying attention to the conversation?" are questions that can be answered with reasonable certainty by these medically knowledgeable interpreters.

Despite these advantages, there are some drawbacks in using bilingual staff members. Since they might be trained in mental health interviewing, they may change the question from the one asked to one they think should have been asked. Their judgment may be accurate, but it adds a complicating factor to the interview as the interviewer will not know if the patient is being evasive, is uncertain of the answer, or was simply not asked the intended question. Since these translators are more familiar with mental health language, they may tend to paraphrase a patient's answers, thereby complicating the assessment of the patient's use of language.

- *Example* – A psychiatrist is interviewing a patient using a mental health technician as an interpreter. The psychiatrist asks if the patient is having any trouble sleeping. The technician speaks for quite a while. The patient gives a brief response and the technician replies: "She does not have any neurovegetative symptoms". Unless this psychiatrist goes back to clarify the exact symptoms, it will be unclear which symptoms were asked about and which were not.

Another issue with hospital personnel is the assumption that all speakers of a language can understand each other equally well. The reality is far different. Spanish speakers taught continental Spanish may have some difficulty understanding a Spanish speaker from rural Columbia. An American may have a similar problems understanding a Scot from Glasgow. Not only are the accents sometimes difficult to understand, but local idioms may be hard to follow.

Remote Interpreters

Many hospitals have turned to the services of paid interpreters who are accessed by phone. The interviewer is in the room with the patient while both are speaking through an interpreter in some distant location. Many of these interpreters are extremely fluent in multiple languages and proficient at their jobs. They have been instructed to ask questions in as close to a word-to-word translation as possible and to convey the answers in a similar fashion. Because they are used to consulting to medical facilities, they are adept at employing medical terms as well as making normal conversation. Since they do not know the patient, they have little bias and can relate responses in a straightforward fashion. When asked, these interpreters can give comments about the patient's use of language and ability to express themselves. They can be asked simple questions about the patient's speech such as "Were they easy to understand?" and "Did they answer the questions appropriately?"

The fact that the interpreter is not in the room, however, adds uncertainty to the translation. Assessing nonverbal cues may be problematic. The interpreter may have difficulty understanding tone and inflection over the phone lines. Although the interviewer has every reason to trust the interpreter, the patient may not choose to do so. If the patient is suspicious of the interpreter, he or she tends to be less disclosing and more evasive. When it comes to asking potentially uncomfortable personal questions, the remote trained professional is generally more comfortable than a family member but less comfortable than the bilingual coworker.

The push toward brevity is a common problem when utilizing an interpreter. The use of a translator often places the interviewer and the patient in an unfamiliar and

uncomfortable circumstance. In addition, the interview often takes much longer than usual. Both the patient and psychiatrist may grow weary of the long pauses and delays in communication. The interviewer may get frustrated with the struggle to get answers for his or her questions. All of these factors may lead the psychiatrist to prematurely terminate the assessment, thereby relying on a minimum of information and/or making unwarranted assumptions. An interpreter may also have a tendency to condense information in an attempt to be more efficient. The interpreter may take the interview's open-ended questions and change them to quicker, close-ended questions, falsely giving the interviewer the idea of limited spontaneous speech by the patient (Farooq and Fear, 2003). The patient may also try to speed up the process by deliberately shortening his or her answers so that he or she will be understood more quickly. This deprives the psychiatrist of an accurate view of the patient's inner world and experiences. All of these can lead to subpar interviews and patient care. The psychiatrist can guard against this by allotting more time than usual for the interview and acknowledging the patient's frustration with the process.

The clinician should meet with the interpreter before the interview to explain the purpose of the interview and to clarify the anticipated questions. If the interpreter has questions about the medical terms being used, these can be addressed prior to meeting with the patient. Further, the importance of word-by-word interpretation and the importance of discerning evidence of a formal thought disorder, neologisms, or hallucinations can be emphasized. If possible, using the same interpreter on subsequent interviews promotes continuity and rapport (Phelan and Parkman, 1995).

After introductions, the psychiatrist will review the role of the interpreter and the mandate of confidentiality. With marginally fluent, English-speaking patients, the interviewer should suggest that an interpreter be brought in. Patients who have good conversational English may find themselves stymied by the demands of a psychiatric interview. Patients may be embarrassed by their limited grasp of the language and might provide answers to what they think was asked rather than request clarification. The interpreter standing nearby gives them another alternative for handling this situation (Phelan and Parkman, 1995).

During the interview, it is important for the interviewer to look at the patient even while the patient responds directly to the interpreter. In employing a remote interpreter, there can be a tendency to look at either the loudspeaker or phone while waiting for answers. This emphasizes the separation between the patient and the interviewer, however, and should be avoided. Observing the patient while he or she speaks also permits the psychiatrist to view nonverbal communications such as affect and mannerisms.

The interviewer should speak at a slightly slower than normal rate but still try to maintain a natural pace and rhythm. The interpreter will sometimes rely on inflection and rhythm of the interviewer to help set the inflection and rhythm of his or her questions. The interviewer should not ask multipart, ambiguous, or complex questions as they often confuse the interpreter and/or the patient.

- *Example* – “Do you have problems with sleep, and if you do, is that a problem getting to sleep, staying asleep, or with waking the next morning?” This inquiry should be broken down into a series of simple, direct questions starting with the open-ended question “Tell me about your sleeping”.

One other specific issue involves the use of sign language. In those cases, the interpreter should be situated beside or slightly behind the interviewer so the patient can watch the interviewer's lips but then move quickly to the signer's hands (Phelan and Parkman, 1995).

Summary of Recommendations

- Use trained medical interpreters whenever possible.
- Ask for word-by-word translation.
- Ask the interpreter about the patient's thought processes.
- Allow for more time than usual.
- Focus on the patient during the interview.

Special Populations – Cross-cultural Issues

Working in a multicultural arena presents a constant challenge for the psychiatrist. Often the same words may have remarkably different meanings for each of the parties requiring additional time to explore issues thoughtfully. Stereotyping and personal biases dramatically alter any clinical relationship. Assumptions about shared experiences are to be avoided.

- *Example* – Both the therapist and the patient grew up as Latinas in a southwestern region of the country. As had been the case for the interviewer, there was an assumption that the church was a central and comforting part of the patient's life. Later, it becomes apparent that the church is united in the patient's mind with her autocratic demanding and abusive father.

Special Population – Telepsychiatry

In an effort to enhance psychiatric coverage to rural and isolated locations, many health systems are turning to telepsychiatry, which allows psychiatric evaluation from a distant location. This is part of an overall increase in the use of information technology to enhance medical care. According to the American Telemedicine Association, 20 million Americans get some part of their health care remotely (Ravn, 2012). Patients who would not be able to see specialists in person can still receive their care through video links to their Primary Care Provider's office.

In addition to reaching isolated populations, another potential advantage of telepsychiatry is cost savings. While purchasing and maintaining the computer and camera equipment at the base location and distant sites can be a significant upfront cost, this will likely be offset by the savings that comes from not having to pay the psychiatrist's travel expenses. A 6-month study compared in-person treatment of depression with telepsychiatry and found that the per session cost of telepsychiatry was more than that of in-person sessions (\$86.16 vs. \$63.25). When travel costs were included, however, the cost became equal with a drive of 22 miles. If the psychiatrist had to drive more than 22 miles to the distant site, then telepsychiatry was less expensive (Ruskin *et al.*, 2004). An additional financial benefit comes from an expected increase in the number of patient contacts. As the provider does not lose time driving to the distant site, he or she has more time to see patients.

There is mounting evidence that in addition to being fiscally beneficial, telepsychiatry provides good quality care. When adequate equipment is used, telepsychiatry can accurately assess cognitive functioning, depressive, anxiety, and psychotic symptoms (O'Reilly *et al.*, 2007). A 2005 meta-analysis of 14 studies with 500 patients found no difference in accuracy or patient satisfaction using telepsychiatry versus in-person evaluations (Hyler *et al.*, 2005).

There have been a number of positive trials examining patient outcomes after receiving telepsychiatry services. One hundred and nineteen veterans with depression were followed for 6 months by in-person psychiatry or telepsychiatry. This study found that depressive symptoms, adherence to treatment, drop-out rates, and satisfaction levels were equivalent. When travel expenses were included, the two treatments were equal in costs (Ruskin *et al.*, 2004). A Canadian study tracked 495 patients who were followed in person or by telepsychiatry. After 4 months of treatment, the patients were reassessed, and both groups had similar improvements in symptoms (O'Reilly *et al.*, 2007).

The United States' Veterans Administration (VA) has promoted the use of telemedicine for mental health services since the early 2000s as a means of reaching out to veterans in rural settings. Between 2003 and early 2012, there had been almost 500,000 tele-mental health encounters with 98,609 veterans. The tele-mental health technology used during 2006–2010 allowed for greater access to evaluations, psychotherapy, and psychoeducational programs. The study also examined the use of mental health resources before and after enrollment and found that the number of admissions and hospital days decreased by nearly 25% after patients enrolled in a telepsychiatry program (Godleski *et al.*, 2012). While telepsychiatry undoubtedly presents exciting opportunities to bring psychiatric services to areas that had been neglected, using telepsychiatry to interview patients creates new challenges.

There are legal and privileging issues that are pertinent to telepsychiatry. Can interviews cross state lines? What are the privileging and licensure requirements if they do? What if patients become agitated during the interview? What if they threaten themselves or someone else? How can the interviewing psychiatrist respond when hundreds of miles away? These questions will need to be answered on a case-by-case basis (Monnier *et al.*, 2003).

Some challenges are strictly technical ones. Compatibility of equipment and software and the adequacy of the available bandwidth need to be addressed. As would be expected, the broader the bandwidth and the better the quality of the picture, the more accurate the assessment. Forty-two patients were assessed in person and via telepsychiatry using a standardized rating scale. The telepsychiatry evaluations were conducted using either narrowband or broadband technology. The quality of assessments utilizing broadband technology was similar to face-to-face interviews. Narrowband technology, however, led to inferior assessments. This decrease in accuracy was likely due to poor image quality and the inability to assess nonverbal cues (Yoshino *et al.*, 2001).

With less than optimal technology, the provider may have difficulty conducting numerous parts of the interview. The psychiatrist may have more difficulty assessing tone of voice. Depending on the camera angle, some important nonverbal cues may go unnoticed. If the patient is not speaking into a high-quality microphone, the clinician may have difficulty hearing or understanding the patient. Eye contact is also difficult to establish. Should the psychiatrist and patient look at the picture on the monitor or into the camera? With adequate preparation, however, many of these problems can be solved.

Before beginning an interview, the psychiatrist should become thoroughly acquainted with the functioning and capability of the equipment. He or she can optimize the experience by having an assistant at the distant site play the role of the patient sitting where he or she would sit and speaking in a normal, soft, and then loud tone. This advance work can also include adjusting the camera and the lighting so that the patient's features and upper body are plainly visible. The psychiatrist can also be positioned to look into the camera while still having a good view of the patient on the monitor.

To minimize the risk of agitation or threatened violence, some locations may choose to have a mental health technician or other medical personnel sitting in the room with the patient. Having this third-party in the session may raise issues of confidentiality and may adversely impact the therapeutic alliance. Another solution to these safety concerns is to have a second line that the provider can use to instantly notify the distant site if the patient demonstrates a deteriorating mental state or expresses concerns about harming himself or herself or others.

The provider should speak in a slightly slow but precise fashion. Early in the interview, significant procedures should be reviewed with the patient. What should be done when the connection is lost? What should occur if the image freezes? What would lead the psychiatrist to contact the distant site for assistance? This is in essence a modified informed consent. Repeatedly checking in with patients during the interview regarding their mood and emotional state is critical since appreciation of nonverbal cues is lessened. Feedback from patients about their ability to see, hear, and understand the psychiatrist is essential as the psychiatrist's ability to see, hear, and understand the patient. Since both the patient and interviewer quickly become aware of the limitations of this modality, asking them to lean forward or speak more slowly is a reasonable request to make.

The US Army began a telepsychiatry program linking Walter Reed Army Medical Center in Washington, DC and Carlisle Barracks in Carlisle, Pennsylvania. They assessed patients' initial concerns about using telepsychiatry services and then followed up about the experience. Nearly a third had concerns about privacy issues before starting telepsychiatry, but, after using the service, that number had been cut in half. Those expressing concerns about confidentiality decreased from 76% before using the program to only 4% with some experience. None of the patients thought that the telepsychiatry experience interfered with their relationship with their psychiatrists. Ninety-six percent eventually agreed that they were comfortable using telepsychiatry services and 84% thought that the care they received was as good if not better than if it had been face-to-face (Schneider, 2006). Although telepsychiatry is still relatively young and the data are limited, with proper safeguards, telepsychiatry appears to be an appropriate venue for psychiatric evaluations.

It is as of yet unclear how telepsychiatry impacts the therapeutic alliance. While patients receiving telepsychiatry often report satisfaction with their interactions with their tele-provider, this may be due to increased convenience and their getting to see a specialist than the creation of a positive relationship with the tele-provider (Monnier *et al.*, 2003). Large-scale studies looking specifically at the therapeutic alliance have yet to be done. It has been suggested that the issue of therapeutic alliance using telepsychiatry may be rapidly shifting as younger generations are increasingly comfortable with carrying out intimate relationships via digital connections (Zur, 2012).

Summary of Recommendations

- Use high-quality, broadband equipment.
- Establish procedures for the handling of emergencies and loss of connection.
- Check in with patient frequently about his or her mood and the interview experience.
- Deliberately attempt to enhance the alliance with the patient.

Conclusions

The psychiatric interview is the psychiatrist's chief means of obtaining information about the patient. Every interview is unique. The life history of each patient is always different from every other patient encountered. When the patient and psychiatrist meet, they are at the juxtaposition of a particular time in the life of the patient and the professional and personal life of the psychiatrist. If they had met 3 months earlier or later, the interview might be considerably different. This chapter has looked at some special circumstances, patient populations, and interactions that frequently create additional challenges for the psychiatrist. By attending to the characteristics of the interview setting and the patient's circumstances, the psychiatrist can adapt strategies and techniques to overcome these difficulties and provide excellent patient care.

References

- Bryant RA and Njenga FG (2006) Cultural sensitivity: Making trauma assessment and treatment plans culturally relevant. *Journal of Clinical Psychiatry* 67(Suppl. 2), 74–79.
- Connor KM, Foa EB and Davidson JRT (2006) Practical assessment and evaluation of mental health problems following a mass disaster. *Journal of Clinical Psychiatry* 67(Suppl. 2), 26–33.
- Farooq S and Fear C (2003) Working through interpreters. *Advances in Psychiatric Treatment* 9, 104–109.
- Feinstein R and Plutchik R (1990) Violence and suicide risk assessment in the psychiatric emergency room. *Comprehensive Psychiatry* 31, 337–343.
- Flynn BW and Norwood A (2004) Defining normal psychological reactions to disaster. *Psychiatric Annals* 34, 597–603.
- Godleski L, Darkins A and Peters J (2012) Outcomes of 98,609 U.S. Department of Veterans affairs patients enrolled in Telemental Health Services, 2006–2010. *Psychiatric Services* 63, 383–385.
- Greenspan SI and Wieder S (2003) Diagnostic classification in infancy and early childhood, in *Psychiatry*, 2nd edn (eds Tasman A, Kay J and Lieberman JA). John Wiley & Sons, Ltd, Chichester.
- Hyler SE, Gangure DP and Batchelder ST (2005) Can telepsychiatry replace in-person psychiatric assessments? A review and meta-analysis of comparison studies. *CNS Spectrum* 10, 403–413.
- Kessler RC, Sonnega A, Bromet E *et al.* (1995) Posttraumatic stress disorder in the national comorbidity survey. *Archives of General Psychiatry* 52, 1048–1060.

Assignment 3

Review the instructions for the Psychiatric Diagnosis assignment in Week Six. This week's assignment will build upon the work you have completed on your chosen case study in Weeks One and Two.

For this assignment, you will construct an outline of your Psychiatric Diagnosis paper. This outline is meant to provide structure for your final assignment, jump-start your thought process on your case study, and ensure you are on the correct path toward the successful completion of your diagnosis.

Your outline should be one to two pages of content and include a brief two- to three-sentence description of each of the required areas listed in the Psychiatric Diagnosis prompt, except for the following two areas:

- Justify the use of the chosen diagnostic manual (i.e., Why was this manual chosen over others?).
- Evaluate symptoms within the context of an appropriate theoretical orientation for this diagnosis.

For these two areas, provide a complete draft of your justification and evaluation based on the case study. You must include explicit information on the theoretical orientation chosen for the case and justification of the use of the diagnostic manual chosen. Research a minimum of five peer-reviewed sources published within the last 10 years to support your choice of theoretical orientation and diagnostic manual. These sources will also be used for the Psychiatric Diagnosis paper. The outline should specify which sources will apply to the justification and evaluation areas.

The Outline for the Psychiatric Diagnosis:

- Must be one to two single-spaced pages in length (not including title and references pages) and formatted according to APA style as outlined in the [Ashford Writing Center](#) (Links to an external site.).
- Must include a separate title page with the following:
 - Title of paper
 - Student's name
 - Course name and number
 - Instructor's name
 - Date submitted
- Must use at least five peer-reviewed sources published within the last 10 years.
- Must document all sources in APA style as outlined in the Ashford Writing Center.
- Must include a separate references page that is formatted according to APA style as outlined in the Ashford Writing Center.

PLEASE USE FIVE peer Reviewed
Sources published within the last
10 years →