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Psychiatric examination and assessment

Patients with psychiatric disorders may refer to a psychiatrist (or other mental health workers) spontaneously or pushed by others (family members, for example). There is also the possibility that the patient accesses treatment against his or her will through compulsory treatment.

The first point of contact is usually the patient's general practitioner, either because the patient is experiencing distressing symptoms or because relatives or friends have noticed something wrong such as atypical behavior or signs of altered functioning. Symptoms and signs are often felt in the body:

- digestive difficulties;
- blood pressure and heart rhythm abnormalities;
- pain symptoms;
- fatigue;
- sleep disturbances, etc.

It frequently happens that pictures with predominantly somatic symptoms are examined from an internist's, neurological, etc. point of view, but not correctly diagnosed from a psychiatric point of view, with a considerable delay in diagnosis and targeted treatment.

The doctor (whatever his or her specialization) must be trained and have the appropriate tools to at least suspect the presence of a psychiatric disorder and send the patient to the psychiatric specialist if necessary. In such cases, referral to a psychiatrist should be accompanied by a clear explanation of the scope of psychiatric practice, particularly to help prevent feelings of shame that may arise.

First contact with the doctor may also occur because of more specifically mental and behavioral abnormalities: isolation, suspiciousness, agitation, depressive or euphoric aspects of mood with abulic or hyperactive behavioral correlates, the onset of bizarre ideas, and so on.

The general practitioner must hypothesize at least diagnostic suspect and, depending on the complexity of the case, may set up a therapy (targeted to the disorder he suspects), and then involve a psychiatric specialist or send the patients directly to the psychiatrist. The psychiatrist must know the patient's general medical condition: the identification and correct classification of psychiatric disorders cannot disregard knowledge of the subject's somatic health status, any medications the patients may be taking, and/or if they use psychoactive substances.

DIAGNOSTIC TOOLS

The main instrument of psychiatric diagnosis is the patient interview. In psychiatry, direct examination, or with instruments, of the patient's body takes second place, complementary, to the patient's narrative. As we have seen, it is a tale of somatic and psychic symptoms that we must carefully investigate in order to grasp their type, severity, time of onset, and course.

A characteristic aspect of psychiatry, and sometimes a more difficult one, is the differentiation between normal and pathological. Since there are no standard biological references available, the data gathered from the patient's account must be compared with a prototype of normal functioning. What can be defined as a physiological mood, a worry that is not anxiety, a fear that is not a phobia, an acceptable rate of rituality that does not constitute an obsessive-compulsive disorder, an ideational oddity that is not a delirium, is influenced by an individual's cognitive and emotional systems, cultural background, and the prevailing norms of the surrounding environment and historical period. In order to be able to distinguish the boundary between pathological and physiological in the most standardized manner possible, it may be helpful to refer to an impairment of the individual's level of psychosocial functioning compared to the previous level, as specified among the diagnostic criteria of the DSM, i.e. Diagnostic and Statistical Manual of Mental Disorders of the *American Psychiatric Association*, which reached its fifth edition in 2013, further revised in 2022 (DSM-5-TR).

Since psychiatric diagnosis is essentially based on the clinical presentation and the patient's narrative, both of which can be derived from the interview, it is evident how indispensable it is to listen attentively to the patient. But pathological ideas, affects, and behaviors coexist with normal ideas, affects, and behaviors. Therefore, we can only operate on the basis of relative differences, which require a comprehensive understanding of the patient's overall patterns of functioning - both current and across the lifespan.

The importance of the psychiatrist's attitude must be remembered, which must be participatory listening, identification with the patient's experi-

ences to fully grasp them. Excessive interventions that can alter the patient's genuine narrative, banal encouragement that disqualifies the doctor, and excessive emotional participation and excessive coldness should be avoided. The first may unsettle the patient who is always afraid of being overwhelmed; the second can make the doctor seem distant and heedless. It should be remembered that this attitude of benevolent neutrality is to be considered appropriate and useful in any kind of medical examination.

Operationally, we can summarize the elements useful for psychiatric diagnosis into necessary and complementary: the former are fundamental to the diagnosis and cannot be disregarded in formulating it, the latter are elements that may contribute to the diagnosis but on which the diagnosis cannot be entirely based. The elements necessary for the diagnosis are:

- the elements reported by the patient (the subjective experience);
- the doctor's assessment of the patient's psychic functioning and behavior (direct psychic examination);
- the patient's general medical condition.

Patient-reported elements

Psychic and somatic symptoms, subjective experiences, personal beliefs, existential history are the direct expression of individual suffering and therefore constitute an indispensable element for the diagnostic formulation; similarly, necessary elements may emerge from subjective experiences that the patient does not report as symptoms because they are not expressions of suffering (e.g. '*I feel great, as I have never felt before', 'I have never slept so little and yet I have never felt so strong*').

Psychiatric examination

Psychic activity can be distinguished into different functions. In the context of normal psychic functioning, these functions are closely integrated, but it is still possible to describe them separately and examine possible alterations. Any psychic function can be altered, and the recognition of this alteration is a necessary element for diagnosis in psychiatry. Of particular importance is the assessment of the following psychic functions:

- *consciousness*: varying degrees of alteration in the state of consciousness can occur, from a slight reduction in lucidity to mental confusion or the loss of conscious mental activity itself. The assessment of consciousness is carried out by evaluating the patient's orientation along three axes: personal orientation (the essential references regarding one's identity and history), spatial orientation and temporal orientation;
- *memory*: memory may be impaired both in its ability to acquire new memories (fixation or short-term memory) and in retaining and bringing back to consciousness acquired memories (recall memory). There is also the possibility that the so-called '*working memory*', which contains the elementary basics on which our operational skills are based, is disturbed;
- *perception*: physiologically, the perceptual function enables the individual to relate to the external world through the sense organs and the corresponding sub-cortical and cortical processing. Perception can be altered quantitatively, producing pictures of hyperesthesia or, conversely, hypoesthesia of the intensity of the sensory stimulus. Qualitative disorders of sense-perception include, for example, erythropsia, micropsia and macropsia (usually due to organic causes or toxic states). The pathological changes of greatest relevance to psychiatry are 'false' perceptions, which are distinguished into:
  - illusions, in which the stimulus is present but is perceived in a distorted manner (abnormal attribution of meaning to a perceived real object);
  - hallucinations, in which perception occurs in the absence of the stimulus-object (thus the patient 'hears' voices, 'sees' disturbing figures, 'smells' particular smells and tastes, 'feels' unusual tactile sensations);
  - pseudo-hallucinations, i.e. hallucinations experienced in inner subjective space and as originating from one's own mind, experienced involuntarily (unlike representation, which is a voluntary and non-psychopathological act);
  - hallucinosis, i.e. hallucinatory perceptions that are partially criticized by the subject, often implying encephalic lesions or toxic states (e.g. alcoholic hallucinosis);

- *thought*: two aspects must be assessed:
  - the content, to ascertain whether there is production of 'delusions', i.e. false beliefs that are clearly inconsistent with reality and common sense, of which the patient is firmly convinced and cannot be dissuaded either by experience or by critical judgment;
  - form, with alterations regarding the syntactic structuring of thought. Formal alterations of thought include the speeding up characteristic of (hypo)mania, a condition where thoughts crowd together with a tendency for ideas to 'escape' (also named 'flight of ideas'), or thought slowing as in depressive states. Other formal alterations are prolixity (the thought reaches the intended goal only indirectly, through excessive elaboration), circumstantiality (the thought is full of irrelevant details), perseverance (insisting on certain content continuously and uncritically). The following formal alterations are characteristic of dissociated thinking, i.e. defined by the disintegration of psychic functions and fragmentation of thought: fusions (meaningless concepts resulting from the condensation of several heterogeneous ideas), hyperinclusions (inappropriate concepts that fit into the logical flow of thought), derailments and tangentialities (deviations of the course of thought from one content to another without ties), barrages (temporary stopping of thought). Finally, thought may be incoherent, autistic or concrete;
- *affectivity*: essentially two forms of alteration may occur:
  - of the mood 'tone', lowering towards the depressive pole or raising towards the manic pole;
  - of the alarm system, with manifestations of anxiety in a persistent form or in the form of panic attacks.

Important and necessary elements may also emerge from the clinical assessment of the patient's behavior. For the assessment of behavior we make use of direct elements (observation or narration by the patient) and possibly indirect elements: information from family members and acquaintances (oddities, overspending, closure, etc.) that the patient is unlikely to report. Observation by family members or other significant figures, and thus the report of any alterations in the patient's behavior compared to the patient's usual way of relating, are in some cases indispensable to make a correct diagnosis.

General medical conditions

Psychic functioning can be modulated or altered by endogenous morbid conditions (somatic diseases) or exogenous substances (drugs, psychoactive substances). It follows that for a correct psychiatric diagnosis it is not possible to disregard knowledge of a possible somatic morbid condition from which the patient is suffering, since there are many psychic abnormalities that can be traced back to an internal or neurological disease. For example: an anxious state with somatic expression may be a consequence of a state of thyrotoxicosis; a confusional state (disorientation with respect to the self, in space and time) may result from a metabolic decompensation; a depressive condition may be a secondary manifestation of a pancreatic carcinoma or the initial sign of Parkinson's disease. Similarly, there are drugs that can alter psychism: in addition to psychopharmaceuticals, alterations in psychic functions that may be due to other types of treatment (cortisone, interferon, thyroxine, estrogen, for example). Finally, it is always advisable to consider whether the subject has taken substances with psychoactive activity (cocaine, amphetamines, alcohol, opiates).

Information concerning the patient's general medical condition is obtained by all possible means: from the patient's own account and that of his or her family members, from clinical records, from information obtained directly from medical colleagues who know the patient. The psychiatrist must, however, perform the general medical examination and the neurological examination. We summarize the reasons why the general medical examination and the neurological examination are always advisable in an initial approach to a patient with mental disorders:

- to verify any general medical conditions or any acute intoxication states that could manifest with psychiatric symptoms (e.g. hyperthyroidism in the case of anxiety disorder);

- to assess the type and severity of somatic symptoms that are related to a diagnosed psychiatric disorder (e.g. alterations in heart rhythm in an anxiety disorder, gastrointestinal function in a disorder with somatic symptoms);
- to assess the physical consequences of abnormal behavior (e.g. anorexia, bulimia, alcoholism);
- to re-evaluate the internist and neurological illness from which the patient is suffering, motivated by the fact that on that type of illness (e.g. angina pectoris, gastro-duodenal ulcer, cerebral stroke) psychic factors can have a significant influence.

It is obvious that doctors with the specific expertise in question must contribute to these assessments.

Laboratory and instrumental investigations, beyond their role in the internist and neurological evaluations mentioned previously, are also useful for:

- assessing the biological correlates of a psychiatric disorder (used to date only in research);
- monitoring psychiatric treatment (e.g. hematological and hematochemical controls in lithium salt treatment).

Complementary elements for the diagnosis of a psychiatric disorder that may be useful are:

- the elements reported by others;
- psychopathological assessment tests and scales.

Elements referred by others

Apart from information of a strict medical nature, it is possible that information on the patient's behavior, attitudes, experiences or existential history may be available from others (close relatives, acquaintances, therapists). As mentioned above, elements reported by others can be a useful contribution to the diagnosis, which must not, however, be overestimated: the meaning of certain behaviors, as well as the emotional correlates of various existential situations, must essentially always be inferred from the patient.

Psychometric tests and scales

Psychodiagnostic tests encompass a broad range of standardized and validated assessments conducted on samples from both the general population and the population affected by mental disorders. There are IQ tests, such as the WAIS (Wechsler Adult Intelligence Scale), tests that measure specific abilities (attention, concentration, verbal memory, visual memory, sense-motor skills, etc.) and questionnaires that guide the diagnosis of mental disorders. The latter are particularly useful for defining the diagnosis according to a precise and determined system of classification of mental disorders: the use of these questionnaires occurs mainly in experimental research and in forensic or insurance psychiatry rather than in clinical practice. Mention should be made here of the Structured Clinical Interview for DSM Disorders (SCID) and the *Millon Clinical Multiaxial Inventory* (MCMI-III) for the diagnosis of personality disorders according to the DSM criteria.

Projective tests consist of more complex assessments of character and personality aspects using instruments that stimulate the patient to elaborate responses based on fantasies and beliefs. In the Rorschach projective test, for example, the patient is confronted with a series of tables (10 in all) representing spots. The patient is asked what he sees in each plate or what makes him think: individual variability in the test answers is very high as the patient projects his own mental representations and subjective emotional states onto a neutral figure. The patient's answers are processed on a grid that is calibrated on a statistical basis, but are also interpreted by the examiner with a certain freedom on the basis of his or her own theoretical reference model.

The Rorschach provides indications on the patient's personality structure and, according to a psychodynamic perspective, on the predominantly adopted defense mechanisms. Indirect elements indicative of the relationship with parental figures, sexuality and affectivity also emerge from the test.

Another well-known projective test, although somewhat obsolete in recent years, is the *Thematic Apperception Test* (TAT), which consists of a series of tables representing various scenes from life. The situations and expressions of the characters are purposely undefined; the patient is asked to interpret them, to tell a story for each board, what happens, how it will end, the feelings of the characters, etc. Again, the interpretation of the test is partly set on a statistical level and partly determined by the examiner's interpretation.

Table1.I. Main rating scales for psychiatric disorders and their area of clinical use.

Self-administered scales	**Area explored**
Stait-Trait Anxiety Inventory (STAI)	State and trait anxiety
Zung Self-Rating Depression Scale	Depression
Beck Depression Inventory (BDI)	Depression
Clinician-administered scales	**Area explored**
Brief Psychiatric Rating Scale (BPRS)	Global psychopathology
Hamilton Anxiety Rating Scale (HAM-A)	Generalized anxiety, panic
Hamilton Depression Rating Scale (HAM-D)	Depression
Montgomery-Åsberg Depression Rating Scale (MADRS)	Depression
Yale-Brown Obsessive Compulsive Scale (YBOCS)	Obsessive-compulsive disorder
Mini-Mental State Examination (MMSE)	Cognitive disorders, dementia
Eating Disorder Inventory (EDI)	Psychogenic eating disorders
Positive and Negative Symptoms Scale (PANSS)	Schizophrenia

Psychopathological assessment scales are standardized and widely validated tools that allow the clinician to quantify the clinical syndrome presented by the patient: they do not serve to formulate a diagnosis (which is primarily clinical), but rather to measure the effect of a specific therapy on symptoms by comparing pre- and post-treatment scores.

There are self-administered scales (the patient fills them in) and clinician-administered scales, which are filled in by the physician on the basis of observation and interview with the patient. Each scale consists of a series of *items* that refer to a specific symptom or sign and, with each item requiring a score that corresponds to a different severity level of the symptom (generally, the score is coded in such a way as to allow several independent observers to measure the same sign/symptom with maximum reliability and reproducibility).

Psychopathological scales are indispensable in research in order to have unified and validated criteria for measuring psychic symptoms; in clinical practice, rather than for the diagnosis of a disorder, they are useful for monitoring the clinical course over time in relation to treatment (pharmacological or psychotherapeutic). Some of the most commonly used assessment scales are listed in **Table 1.I.**

CLASSIFICATION OF PSYCHIATRIC DISORDERS

Before proceeding to a systematic discussion of individual psychiatric disorders, some additional preliminary remarks must be made. As mentioned earlier, the diagnostic process in psychiatry starts by attempting to distinguish a pathological condition from normality. Psychiatric diagnoses are "constructed" following two different possible approaches which are codified in the two classificatory systems of mental illnesses currently used not only in Italy but throughout the world.

The first system is the World Health Organization's *International Classification of Diseases* (ICD), now in its 11th edition (ICD-11) in 2019. This classification model of mental disorders is called 'prototypical' (based on prototypes, i.e. narrative descriptions of disorders). The clinician's task is to determine which of the various prototypes of mental disorders best corresponds to the symptomatological presentation of the individual patient. This approach is very close to common clinical practice, but leads to variability in psychiatric diagnoses between different practitioners and is therefore not used much in research.

A second diagnostic-classification system is the one already mentioned by the *American Psychiatric*

Association, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), currently in its fifth revised edition (DSM-5-TR).

This system is based on operational criteria, i.e. on a predetermined set of criteria that must necessarily be met in order to reach a diagnosis. The clinical procedure required of the psychiatrist involves verifying whether the criteria defined by the manual for each specific disorder are met by the individual patient; in particular, for each psychiatric diagnosis, there are:

- *symptomatological* criteria (a number of signs or symptoms that form the psychopathological picture);
- *temporal* criteria (the signs and symptoms must have been present for at least a certain period, which differs from one disorder to another);
- *functional criteria* (these signs and symptoms, present for a certain period of time, have impaired the patient's functioning and/or created clinically significant distress).

This approach to diagnosis is certainly very rigid and, in some ways, superficial, but it has the advantage of the reproducibility of diagnoses and is widely used in clinical and therapeutic studies.

The individual disorders are then classified according to the predominantly altered psychic function: disorders involving an alteration of the alarm system, for example, are classified together in the chapter *Anxiety Disorders and Trauma-Related Disorders*; disorders in which the predominantly impaired function is affectivity/mood tone are included in the chapter *Depressive Disorders* and *Bipolar Disorder and Related Disorders*; disorders characterized by prevalent alterations in perception and thought content form the chapter *Schizophrenia Spectrum Disorders and Other Psychotic Disorders*, and so on.

Finally, it seems useful to us to recall the need to follow a sequential approach. By this we mean that the clinician must begin, in the diagnostic process, from the current diagnosis: thus, recognizing what psychopathological picture is currently present (obviously having first recognized that the set of symptoms and signs presented constitutes a psychopathological picture). It is then necessary to ascertain since when the presented psychopathological picture has been present (*for how many days/months have the symptoms and signs that constitute the picture been present?*). Only at this point is a longitudinal diagnosis made:

- *what is the patient's clinical history (of psychiatric interest)?*
- *have previous episodes characterized by the same symptomatology been present in his life (e.g. affective episodes, and in this case of what polarity - only major depressive or also manic)?*
- *have there been episodes characterized by different symptoms/signs, referable to another psychiatric diagnosis (e.g. psychotic episodes in a person with personality disorder)?*

Finally, but only after the current and longitudinal diagnosis have been made, it is necessary to look at the patient's life history by evaluating possible correlations between significant life events and the episodes of illness.

It should be noted that life events can be either triggering events or symptomatological/behavioral alteration directly attributable to the psychopathological picture. This is the case of a family argument, which can cause a consequent mental alteration (for example an anxiety state with physical correlates) or be the symptom of a pre-existing state of agitation due to a psychiatric condition (e.g. borderline personality disorder, manic episode, etc.).

This approach is valuable in clinical practice not only because it enables the detection of subtle behavioral changes in the patient's past that may have manifested through life events and were not previously recognized as expressions of pathological alterations, but also because it allows patients to reframe experiences of guilt, for example, in light of a psychiatric disorder that has affected their relational, family, or occupational life.