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AN INTRODUCTION TO INTEGRATED PSYCHIATRIC EVALUATIONS

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"*It is much more important to know what sort of patient has a disease than what sort of disease the patient has*." Sir William Osler, M.D.

The treatment of illness and disease has become a highly technical scientific endeavor. Medical knowledge involves understanding the biochemical and mechanical substrates of illness and disease, ranging from gross physiological pathology to intra-systemic interactions to sub-cellular biochemical and genetic phenomenon; and treatment interventions now include mechanical aids and assistance, pharmacological interventions, surgical and invasive procedures, and even genetic manipulation. However, with the advent of so many sophisticated and "high-tech" interventions, particularly in the statistically-based environments of "Evidence Based Medicine", "Managed Care", the heart of understanding and healing *patients* has been all but lost, in favor of the focus upon the addressing specific symptomatology and pathology.

This phenomenon has significantly impacted how non-psychiatrists understand dealing with the emotional and psychological issues that may arise of themselves, or may accompany, complicate, and/or interfere with attempts to provide effective treatment for somatic, non-psychiatric maladies. This phenomenon has also altered the way that both non-mental health professionals and unsophisticated mental health professionals (particularly those in training) evaluate patients who present with primary psychiatric complaints/symptomatology. Additional budgetary and related practical pressures have also contributed to a symptom-oriented approach, rather than a patient-oriented approach, in evaluating emotional distress and psychopathology.

There is little dispute that there is a complex interface and interaction between somatic symptomatology, psychological symptomatology, underlying pathology, and indicated interventions and treatment strategies. There is also little doubt that especially for

more minor emotional difficulties, brief and rather superficial intervention may suffice to contain acute symptomatology. In fact, in common language, especially within the non-psychiatric community, psychopathology and emotional distress are often referred to rather generically as "stress-related problems". However, the situation is much more complicated, as “stress” is in fact, a generic and nonspecific term. While it is not infrequent that in non-psychiatric medical records the term “stress reaction” is used as a diagnosis – this is no more meaningful in describing the actual nature or seriousness of the problems or pathology present than it would be to use the diagnosis of a “heat reaction” for a patient with a burn injury, without differentiating between a first degree burn that requires little but first-aid attention, as opposed to a life-threatening third degree burn.

Although the interactions between physiological, psychosocial and behavioral phenomena can be extremely important factors throughout the practice of medicine, mental health evaluation and treatment is all the more complicated in that regard. On the most basic level, if a patient is not cooperative and compliant with treating practitioners' instructions, treatment can be compromised or sabotaged. In order to be cooperative and compliant, a patient must understand and appreciate the importance of the instructions that he or she is being given. There are frequently times when psychological and emotional factors may interfere with the patient’s understanding, acceptance and cooperation with prescribed treatment interventions – but those issues can easily be overlooked by a practitioner who is not aware of the psychological dynamics of the individual person being treated. Emotional and behavioral responses to both the process of evaluating psychiatric difficulties and the recommendation of treatment interventions for those problmes are very intricate, and are difficult to predict and/or manage unless there is an understanding of the complexities of the psychology of the particular individual patient, as well as the concomitant life circumstances, personal/family problems, social issues, existential issues, and medical factors which are concomitantly present. Such factors can trigger conscious behavioral difficulties and/or unconscious acting out or psychophysiological responses of the body which can interfere with the evaluation and treatment processes. There are complicated interactions between the musculoskeletal system, immune system, hormonal systems, autoimmune reactions, the nervous system, the dermatological system, and perhaps even extending down to a cellular/genetic level, which can be triggered by "stress", affective malaise, anxiety, dysphoria and/or emotional conflicts. These neuro-hormonal-psychophysiological interactions can mask or exacerbate underlying psychopathology, which in turn can negatively impact the efficacy and effectiveness of prescribed interventions which may only be addressing a limited subset of contributory factors. While we generally give lip-serve to recognizing the “bio-social-psychological” substrates of psychopathology, practically, “in the real world”, recognizing the impact of the interaction between somatic, psychophysiological and psychological factors is often neglected in the rush to find an “evidence-based” intervention which will address a specific symptom. In superficial cases, simple intervention can offer adequate relief; but in many cases, the results of overly simplistic treatment protocols resemble the story

of the “blind men and the elephant”, wherein various different “specialists” are each perceiving and reacting to only a limited aspect of the totality of patient’s problems, and the resulting treatment interventions not only lack in being holistic or well-integrated, but not infrequently can be negatively interactive and ultimately counter productive.

Obviously, in emergency or life-threatening situations, whether the situation is primarily medical or psychiatric, the subjective experiences of the patient (beyond adequately controlling pain, and obtaining what basic compliance is necessary) are of secondary importance to the interventions which are indicated to maintain safety. However, once the emergent or life-threatening conditions have been resolved or is sufficiently reduced, if an evaluator does not understand the *patient* in whom the disease or injury has occurred, the interventions provided may be far less than optimally effective, may be significantly sabotaged, may be rendered essentially futile, or in the most severe cases, may even turn dangerously counterproductive.

Formally, psychiatric diagnosis, as per the DSM, is based upon a system of diagnostic Axes. Axis V is used to describe a person’s level of functioning, and does not contain diagnoses *per se*, and similarly, Axis IV describes the situational stresses which may be impacting a person’s presentation, rather than providing specific diagnoses. Axis III is reserved for summarizing concurrent non-psychiatric medical conditions which must be recognized in appropriately treating the patient. Axes I and II are the “heart” of the psychiatric diagnosis – Axis I describing the acute pathology/symptomatology which is present, and Axis II describing the patient’s personality structure, and any problematic characterological traits or “personality disorder” which may be present.

However, perhaps the system of diagnostic “Axes” has made us lazy. While it is clearly a good idea to understand the difference between acute symptomatology and characterological pathology, there is no room in the DSM-style diagnostic description to provide a specific description of the <u>interaction</u> of “Axis I pathology” and “Axis II pathology”, nor the interactions between the psychopathology present as indicated on those axes, with the situational factors, stressors and medical issues which may be listed on Axes III and IV. In reality, in every case, there is always a *complex and unique interplay* of acute symptomatology and underlying characterological structure, as well as external biological, psychological and social factors.

In order to provide comprehensive and optimal treatment, there should be a comprehensive <u>Case Formulation</u> constructed. A Case Formulation is a detailed description of the *person* seeking treatment, including <u>integrating</u> issues of acute symptomatology; historical data; characterological strengths and weaknesses; underlying unresolved emotional conflicts; the nature of psychological defenses being employed; and presence of situational biological, psychological and social issues which need to be attended to.

Problems can occur when issues regarding how to integrate all of that data are impacted by the particular "philosophy" or "school of thought" of the evaluating practitioner – ranging anywhere from the reductionism of the "pure" biological psychiatrist, to the intricate meta-psychology of a "traditional psychoanalyst" – and even within those stereotypical groupings, there are certainly differences of opinions and philosophy (all biological psychiatrists do not share the exact same opinions regarding current theories of neurotransmitters, drug interactions, etc.; and certainly, all psychoanalysts are not of one ilk). In that regard, attempting to train emerging practitioners (mental health students, or non-mental health medical personnel who may be form the "front line triage" for patients) can become devastatingly mired in philosophical debates or "turf wars" among competing theories of psychopathology.

Nonetheless, any system of psychiatric classification and categorization has three basic purposes: 1) to describe phenomena in an orderly, logical and consistent manner which aids in the understanding of the pathology; 2) to provide a system of organization of data which aids in the predication of future related phenomena; and, 3) to provide a system of organization of data which aids in the development of interventions which can effect positive changes.

Thus, while only through an in-depth evaluation over time can a sophisticated mental health treatment practitioner develop a detailed Case Formulation, it behooves practitioners providing initial evaluations to at least develop a general understanding of the process of integrated psychiatric evaluation and an understanding of the nature of psychopathology free of philosophical bias, in order to aid in steering the patient towards optimal mental health treatment. Even in the most "simple" primary care settings, multiple studies have shown that a very significant percentage of visits to the physician are actually precipitated by emotional or psychosomatic/psychophysiological phenomena – but if the evaluation of those patients is unduly superficial, any and all treatment interventions based upon that evaluation may prove ineffective, inadequate or even iatrogenically dangerous.

There is generally a hierarchy of evaluation and treatment of medical or psychiatric problems, which follows the pattern of three Levels:

> Level 1) Evaluation of any immediate danger and institution of appropriate life support measures;
>
> Level 2) Evaluation of impairment of functioning and institution of palliative measures; and,
>
> Level 3) Evaluation of the pathological process involved and institution of interventions to reverse, relieve, or adjust to those processes so as to restore as close to normal and "healthy" functioning as may be possible.

However, this does not imply that evaluation of each of these areas is always temporally independent. That is, even though there is a necessity to prioritize the formal evaluation

process and provision of intervention as per those three levels, data is being simultaneously collected regarding all three levels.

I have set out to provide a general core protocol of evaluation which takes into account all of the complexities involved, and leads to informed treatment decisions, but avoids being compromised by an un-integrated or biased philosophical point of view.

Level I concerns evaluation and intervention regarding immediate danger. Medically, there is a clear-cut process of evaluating respiration, pulse, bleeding, etc. Psychiatrically, this evaluation proceeds by assessing:

1) What is probability of this person acutely acting in such a way to directly harm himself or herself? (i.e., evaluation of suicidal potential);
2) What is the probability of this person acutely and directly harming others? (i.e., evaluation of homicidal and violent potential); and,
3) What is the probability of this person acutely and directly involving him or herself in a situation which is likely to cause harm to self or others, even if this is not the person's intent? (i.e., evaluation of reality testing and judgment).

However, even if acute danger is contained but underlying psychopathology is not also identified, the risk of future potentially dangerous decompensation is high.

Level II concerns evaluation of impairment which does not present an immediate danger, but causes a significant compromise of functioning. Psychiatrically, impairment may be due to psychosis, anxiety, depression, etc. There are certain interventions available (essentially psychopharmacological interventions) which may temporarily remove or even permanently reduce or resolve the impairment *regardless* of the theoretical underlying pathological process. At times, such measures are immediately necessary, in that the impairment itself blocks further evaluation of the underlying process. However, instituting non-specific palliative measures must be recognized as potentially interfering with evaluation of the underlying process – which in turn which may detract from the determination of other necessary and indicated medical or psycho-social interventions <u>even though manifest symptomatology has been contained</u>. That is, without understanding the nature of acute impairment on a deeper level, it can not be predicted whether a palliative intervention will suffice, and whether or not a palliative intervention will serve to 1) decrease the probability of a recurrence of the problematic symptomatology/behavior; 2) have no effect upon the probability of a recurrence; or, 3) potentially increase the probability of recurrence of the pathological situation. For example, simply reducing a patient's manifest anxiety may at times <u>increase</u> the risk for future antisocial or dysfunctional behaviors. Thus, similar to the caveat offered regarding evaluating immediate danger, in evaluating the level of impairment, as a general rule, interventions should be selected which will relieve the significant acute

impairment of functioning while having the least unpredictable effect upon the underlying pathological process.

Level III involves the process of evaluating the nature of underlying pathology. When the specific etiology of the condition can be easily specified, this may constitute a definitive initial evaluation (e.g., if symptomatology is arising from a metabolic or neurological condition, such as a thyroid disorder, an infectious process, or a brain insult, then immediate understanding of the etiology of the disorder is imperative, and referral for appropriate medical treatment is necessary). However, when the situation is not that "clear cut" and involves a greater degree of psychologically-based pathology, from a practical point of view, what is most important is determining the interventions which will provide a reduced risk of future dysfunctional symptomatology or dangerous behaviors. Reducing practical risk is primary to gaining a precise "theoretical" knowledge of the "cause" of the pathology, Specifically, when dealing with problematic affective symptomatology or behaviors in the absence of overt physiologically pathological factors, determining whether the symptoms are "caused" by "chemical imbalances", "unresolved emotional conflicts", or "underlying psychodynamics" is less acutely important than determining what interventions (psychopharmacological, psychotherapeutic and/or psycho-social) will be most effective in containing the dysfunctional phenomena over time. That is, the focus must be upon determining effective practical interventions, rather than theoretical issues regarding the etiology of psychopathology.

Once the need to immediately address acute issues has been ruled out or resolved, patients can be evaluated regarding how they might fit into four general "Populations", based upon a more comprehensive understanding of the nature of their acute presentation, yet maintaining an essentially atheoretical standpoint vis-à-vis the argument of biochemical imbalance versus psychodynamics, or nature versus nurture. Ascertaining which Population which best describes a particular patient is relatively easy to evaluate in a general medical setting or triage setting, simply by taking a complete history, without the need for technical psychological testing, nor developing a definitive psychiatric diagnosis employing any specific theoretical bias.

Population 1 may be defined as patients presenting with a symptom complex which is a highly probable to occur in this particular patient at any particular time; i.e., the dysfunctional phenomena essentially is an aspect of the person's baseline level of functioning (e.g., a person with a full-blown affective disorder or definitive personality disorder). *This determination is made by taking an adequate history of the patient's level of symptomatology and functioning prior to the acute presenting problem.*

Population 2 patients exhibit a symptom complex which is more episodic, and does not represent a constant aspect of the patient's baseline level of functioning, but nonetheless can be expected to recur with some frequency. That is, this is a situation of having to address intermittent acute "symptomatic episodes" in a person who has a

chronic vulnerability/propensity to such episodes. (e.g., a person who harbors emotional vulnerabilities, but who only becomes symptomatic or behaviorally dysfunctional in the face of particular, but not necessarily unusual life stresses. Such life stresses may include problems in a personal relationships, occupational or financial difficulties, general life frustrations, or reactions secondary to indulging in the use of psychoactive drugs). *This determination is made by taking an adequate history of the patient's level of symptomatology and functioning prior to the acute presenting problem, and then investigating the "triggering" factors for various episodes of acute symptomatology.*

Population 3 patients exhibit a symptom complex which must be considered either totally unexpected based upon the patient's history, and understandable only in the light of a catastrophic life stressor (i.e., a person faced with potentially disastrous life circumstances; or who is suffering from post-traumatic symptomatology in the face of an objectively traumatic experience). *This determination is made by taking an adequate history of the patient's level of symptomatology and functioning prior to the acute presenting problem, and then investigating the "triggering" factors for this specific and unique episode of acute symptomatology.*

Population 4 patients present with acute symptomatology which has emerged unexpectedly, without any known or immediately identifiable pre-existing vulnerability or acute precipitating events or stressors.

Based upon the above discussion, the process of the psychological evaluation can be summarized by the following outline, which is not dependent upon any one particular theory or psychopathology:

Level I – Evaluation of immediate danger

Evaluation 1: What is the acute, direct, suicidal potential of this person?

Intervention 1: Determine acute medical, psychiatric, practical and psycho-social/legal interventions required to decrease the suicidal danger.

Evaluation 2: What is the acute, direct, homicidal potential of this person?

Intervention 2: Determine medical, psychiatric, practical and psycho-social/legal interventions required to decrease the homicidal suicidal danger.

Evaluation 3: What Is the acute, direct, potential danger to this person or to others considering any impairment in this person's reality testing and judgment?

Intervention 3: Determine medical, psychiatric, practical and psycho-social/legal interventions required to decrease the potential for this patient becoming unintentionally dangerous to self or others.

Level II – Evaluation of impairment

Evaluation 4: What impairments of functioning are present which constitute an obvious danger of irreparable damage to this person's life situation, (e.g., ability or inability to provide a medical history; ability or inability to cooperate with medical treatment)?

Intervention 4: Determine the immediate medical, psychiatric, practical and psycho-social interventions required to at least temporarily improve the patient's ability to function cooperatively.

Evaluation 5: What impairments of functioning are there which present somewhat more subtle obstacles to effective attention to the patient's problems (e.g., histrionic symptomatology, symptom magnification, somatoform symptomatology, psychophysiological symptomatology; drug seeking behaviors; acting out of dependency needs, etc.)

Intervention 5:
A) Determine the immediate medical, psychiatric, practical and psycho-social interventions required to at reduce manifest symptomatology, disruptive intentional/conscious behaviors, and/or address as possible unconscious emotional conflicts which are leading to interference in the patient's life functioning (personal, family, academic, occupational, etc.) and/or interfering with the effectiveness of necessary medical diagnosis and treatment of *bona fide* physiological disorder/disease. For example, measures to reduce immediate anxiety; measures to inform and/or reassure family members or others in attendance who may be unwittingly reinforcing dysfunctional behaviors.

B) Refer the patient for a more comprehensive evaluation regarding the need for longer-term interventions.

Level III – Evaluation of underlying pathology

Evaluation 6: Population One – Is the current presentation an aspect of the patient's baseline level of functioning?
If no, go on to Evaluation 7.

If yes:
Intervention 6: Refer the patient for a long-term, multi-disciplinary plan for treating the pathology and symptomatology present, addressing as possible all relevant biological, psycho-social and psychological/psychodynamic. (Specific interventions in that regard may well depend upon the "psychological theory and bias" of the treating practitioner, but those are not issues which need to be addressed in the immediate evaluation setting.)

Evaluation 7: Population Two – Has this particular symptom complex or behavioral dysfunction been the result of an acute stressor or event in an inherently vulnerable patient?
If no, go on to Evaluation 8.

If yes:
Intervention 7: Making use of a multi-disciplinary approach, address the acute symptomatology with particular attention to the specific situation which has triggered that symptomatology; and then, as in intervention 6, as possible, refer the patient for a long-term treatment protocol to address the underlying vulnerability.

Evaluation 8: Population Three – Is the current symptom complex and/or dysfunctional behavior the result of an unexpected, unpredictable, catastrophic event?

Intervention 8a: Determine what multi-disciplinary interventions are necessary to decrease acute symptomatology (support, palliative symptomatic relief, post-traumatic treatment protocols, etc.);
Intervention 8b: Determine if the severity of any identified catastrophic event and resulting emotional decompensation has caused a long-lasting or permanent change in the patient's practical level of functioning, sense of security, life circumstances, sense of identity, and/or characterological defenses (a "lighting up" of previous repressed or quiescent emotional conflicts or vulnerabilities), – i.e., as to create essentially a "new baseline" level of psychological functioning – and if so, return to Interventions 6 and 7 to appropriately address those issues

Evaluation 9: Population Four – Acute symptomatology has emerged unexpectedly, without any known or immediately identifiable precipitant

Intervention 9: Refer the patient for a more in-depth multi-disciplinary evaluation, perhaps making use of protocols such as psychological testing, additional medical evaluation, neuropsychological testing, interviewing friends or family, etc.