

In Psychiatry, Good Treatment Starts with Accurate Diagnosis

Norman Sussman, MD



Most of the articles in this issue of Primary Psychiatry address different ways to diagnose mental disorders and their manifestations. Given the reliance on diagnostic criteria and rating scales, our understanding of what clinical entities represent are constantly evolving. It is important that we keep current about any data that improve our efforts to understand the disorder at hand.

It is well known that patients with panic disorder are frequent visitors to emergency departments, usually with fears they are having a heart attack. Geneviève Belleville, PhD, and colleagues describe how the characteristics of patients with panic disorder in an emergency room differ from patients seen in psychiatric settings with respect to panic symptoms, comorbid psychiatric disorders, and psychological correlates of panic disorder. They assessed >2,000 patients seen either in an emergency department or anxiety disorder clinics. The authors report that men were more likely than women to go to an emergency room. Those in the emergency room sample were also more likely to have recently experienced suicidal ideation. Of interest was the finding that patients from the emergency department had less severe panic symptoms, but had higher rates of psychiatric comorbidity, most notably other anxiety disorders and major depressive disorder. Other differences between the groups are discussed in the article.

As a reminder, the American Psychiatric Association (APA) has just released the draft disorders and disorder criteria that have been proposed by the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* Work Groups.¹ As part of the development process of the *DSM-5*, set for publication in May 2013, the preliminary draft revisions to the current diagnostic criteria for psychiatric diagnoses are now available for public review and comment. The draft criteria are listed in Table 1.

Another anxiety disorder addressed in this issue is obsessive-compulsive disorder (OCD). Ashish Aggarwal, MD, and colleagues provide a case report of obsessive-compulsive symptoms following administration of clozapine. There have been numerous reports of OCD emerging or becoming exacerbated during the treatment of schizophrenia with atypical antipsychotics. In the reported case, these symptoms were dose related. The authors discuss possible explanations for this phenomenon. Incidentally, the APA work group is recommending that this OCD be included under a grouping of anxiety and

obsessive-compulsive spectrum disorders, with the diagnostic criteria listed in Table 2.

The common dilemma of how to treat anxiety and insomnia in patients with chronic alcohol use disorders is addressed by Aazaz U. Haq, MD. Using an evidence-based approach, he describes many pharmacologic strategies that rely on off-label use of various agents and advocates concurrent use of cognitive behavioral therapy.

TABLE 1

PANIC DISORDER (INCLUDES PREVIOUS DIAGNOSES OF PANIC DISORDER WITH AGORAPHOBIA AND PANIC DISORDER WITHOUT AGORAPHOBIA)

- A. Recurrent unexpected panic attacks
- B. At least one of the attacks has been followed ≥ 1 month of one or both of the following:
 1. Persistent concern or worry about additional panic attacks or their consequences (eg, losing control, having a heart attack, going crazy).
 2. Significant maladaptive change in behavior related to the attacks (eg, behaviors designed to avoid having panic attacks), which may include agoraphobic avoidance.
- C. The panic attacks are not restricted to the direct physiological effects of a substance (eg, a drug of abuse, a medication) or a general medical condition (eg, hyperthyroidism, cardiopulmonary disorders).
- D. The panic attacks are not restricted to the symptoms of another mental disorder, such as social phobia (eg, in response to feared social situations), specific anxiety disorder (eg, in response to a circumscribed phobic object or situation), obsessive-compulsive disorder (OCD; eg, in response to dirt in someone with an obsession about contamination), posttraumatic stress disorder (eg, in response to stimuli associated with a traumatic event), or separation anxiety disorder (eg, in response to being away from home or close relatives).

OCD=obsessive-compulsive disorder.

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Dr. Sussman is editor of *Primary Psychiatry* as well as Associate Dean for Post-Graduate Programs and professor of psychiatry at the New York University School of Medicine in New York City.

Dr. Sussman reports no affiliation with or financial interest in any organization that may pose a conflict of interest.

Email questions or comments to ns@mbcommunications.com

David Goodman, MD, and colleagues report on interpreting attention-deficit/hyperactivity disorder rating scale scores. The article supports the evidence that improvement on a rating scale translates into clinically significant symptom reduction. Conversely, Leo Baestiaens, MD, notes that measurement-based approaches to patient care that rely on validated rating scales may in fact be less helpful than believed. Addressing the care of patients with schizophrenia, he argues that professionals interact more with their patients and spend more time with them. This, of course, would require higher reimbursement rates.

TABLE 2
OBSESSIVE-COMPULSIVE DISORDER

- A. Either obsessions or compulsions:
Obsessions as defined by (1) and (2):
1. Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted and that usually cause marked anxiety or distress.
 2. The person attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion).
- Compulsions as defined by (1) and (2):
1. Repetitive behaviors (eg, hand washing, ordering, checking) or mental acts (eg, praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly.
 2. The behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive.
- B. The obsessions or compulsions are time consuming (eg, take >1 hour/day), or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- C. (formerly Criterion E.). The disturbance is not due to the direct physiologic effects of a substance (eg, a drug of abuse, a medication) or a general medical condition.
- D. The content of the obsessions or compulsions is not restricted to the symptoms of another mental disorder (eg, excessive worries about real life problems in generalized anxiety disorder; preoccupation with food or ritualized eating behavior in an eating disorder; hair pulling in trichotillomania; stereotypies in stereotypic movement disorder; preoccupation with appearance in body dysmorphic disorder; preoccupation with drugs in a substance use disorder; preoccupation with having a serious illness in hypochondriasis; preoccupation with sexual urges or fantasies in a paraphilia or compulsive sexual behavior; preoccupation with gambling or other behaviors in behavioral addictions or impulse control disorders; guilty ruminations in major depressive disorder; paranoia or thought insertion in a psychotic disorder).
- Specify whether OCD beliefs are currently characterized by:
Good or fair insight: Recognizes that OCD beliefs are definitely or probably not true, or that they may or may not be true
Poor insight: Thinks OCD beliefs are probably true
Delusional beliefs: Completely convinced OCD beliefs are true
Specify if: Tic-related OCD: The individual has a lifetime history of a chronic tic disorder

OCD=obsessive-compulsive disorder.

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In a case report, Ravi C. Sharma, MD, and Rajeshwar S. Thakur, MS, offer a reminder that conversion symptoms do indeed still occur. They report the case of a woman with acute urinary retention manifesting as a conversion symptom.

Finally, I want to share with you a communication I received from one of our readers about a December 2009 article by Galit Ben-Amitay, and colleagues² about the psychiatric assessment of children with poor verbal capacities using a sandplay technique. Erno Daniel, MD, PhD, at the Sansum Clinic in Santa Barbara, CA wrote:

“An interesting offshoot of the study you reported could be the following. When my children were young, we built a sandcastle on the beach. When we tired of playing with it, we sat away from it in the sand doing other things. A little child came by. As he approached the sandcastle, it occurred to me that he had several choices: 1. Sit and play with it. 2. Add on to the sandcastle and make it better to suit his own imagination. 3. Kick it to bits and walk away.

The latter is what happened. It occurred to me that the ‘sandcastle test’ may have predictive correlates with future behavior: fit-in personality versus creative/progressive personality versus destructive personality. I would welcome a study to see if such is true.” *PP*

REFERENCES

1. Proposed Draft Revisions to DSM Disorders and Criteria. Available at: www.dsm5.org/Pages/Default.aspx. Accessed February 17, 2010.
2. Ben-Amitay G, Lahav R, Toren P. Psychiatric assessment of children with poor verbal capacities using a sandplay technique. *Primary Psychiatry*. 2009;16(12):38-44.