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KAPLAN & SADOCK'S
CONCISE TEXTBOOK OF
**CLINICAL
PSYCHIATRY**

Derived from Kaplan & Sadock's Synopsis of Psychiatry, Twelfth Edition

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CONSULTING EDITOR

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FIFTH EDITION

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Preface

The Kaplan and Sadock series comes in a matryoshka dolls assortment of sizes. As the title implies, the *Concise* textbook is one of the briefer in the series. It is an abridgment of the larger volume, *Kaplan & Sadock's Synopsis of Psychiatry*, twelfth edition, a condensation of the *Comprehensive Textbook of Psychiatry*. The *Synopsis* covers both the behavioral sciences and the diagnosis and treatment of psychiatric disorders.

This book eliminates the behavioral science chapters and focuses on those chapters that are the most clinically relevant. We designed it to meet readers' needs who require a compact but thorough clinical psychiatry coverage.

We also wrote this book to serve diverse professional groups: psychiatrists and nonpsychiatric physicians, medical students, psychologists, social workers, psychiatric nurses, and other mental health professionals, such as occupational and art therapists, among others.

Our organization here follows the organization used in the *Synopsis*. Whenever we could, we grouped disorders syndromally. Thus, we first discuss the various depressive disorders' phenomenology as a group before discussing diagnosis and, eventually, treatment. This approach was a strategic choice as much modern research no longer groups patients by clinical diagnoses, and many incorporate larger groupings: depressed patients or psychotic patients, for example. However, we did not over-reify our desire for organization and consistency, and in cases where the disorders within a chapter are fundamentally different, we include separate sections for each.

The overarching philosophy we bring to this work is that mental health is part of physical health, and one cannot discuss psychiatric disease except within the context of all medicine. Even the term "mind-body" seems obsolete and implying a divide that does not exist. We were frequently reminded of this as we edited during the COVID-19 pandemic and witnessed how a simple virus can wreak such havoc on the psyche of our patients, faculty, and trainees.

COMPREHENSIVE TEACHING SYSTEM

This textbook forms one part of a comprehensive system developed to facilitate the teaching of psychiatry and the behavioral sciences. At the head of the system is the *Comprehensive Textbook of Psychiatry*, which is global in depth and scope; it is designed for and used by psychiatrists,

behavioral scientists, and all mental health professionals. The *Synopsis of Psychiatry* is a briefer, highly modified, and current version suitable for medical students, psychiatric residents, practicing psychiatrists, and mental health professionals. Along with this *Concise* textbook, the *Concise Textbook of Child and Adolescent Psychiatry* describes all psychiatric disorders, including their diagnosis and treatment in adolescents and children. Another part of the system, *Study Guide and Self-Examination Review of Psychiatry*, consists of multiple-choice questions and answers; it is designed for students of psychiatry and for clinical psychiatrists who require a review of the behavioral sciences and general psychiatry in preparation for a variety of examinations. The questions are consistent with the format used by most standardized examinations. Other parts of the system include the *Pocket Handbook of Clinical Psychiatry*, and the *Pocket Handbook of Psychiatric Drug Treatment*. They are designed and written to be carried by clinical clerks and practicing physicians, whatever their specialty, as a practical reference. Together, these books create multiple approaches to the teaching, study, and learning of psychiatry.

CLASSIFICATION OF DISORDERS DSM-5

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ICD-10

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Readers also should be aware of a parallel classification system developed by the World Health Organization

(WHO) called the *International Statistical Classification of Diseases and Related Health Problems* (ICD-10). There are textual differences between DSM and ICD, but according to treaties between the United States and the WHO, the diagnostic code numbers are identical to ensure uniform national and international psychiatric statistics. ICD diagnoses and numerical codes are accepted by Medicare, Medicaid, and private insurance companies for reimbursement purposes. ICD-10 is a comprehensive list of all medical diagnoses, not just psychiatric diagnoses. It tends to be descriptive and allows more judgment than the DSM-5, which contains fixed numbers of criteria. ICD-10 is also older than DSM-5 and contains diagnoses no longer included in the newer manual. ICD-11 is currently available in draft form and is online at the WHO's website. The ICD-11 is more aligned with DSM-5. The WHO plans to for this new edition to go into effect in 2022. As much of the world still uses ICD-10 (including the United States, especially for billing purposes), we include it in our tables devoted to diagnostic reading. The reader will note the many similarities between DSM-5 and ICD-10 in those tables, as well as some interesting differences.

CASE HISTORIES

Case histories are an integral part of this textbook. They are used extensively throughout the text to add clarity and bring life to the clinical disorders described. Cases come from various sources. Many are from the Sadocks'

hospital colleagues or their personal experience at Bellevue Hospital in New York. We have preserved most of these case studies as we believe that they expertly illustrate the sometimes abstract concepts described, and we thank the many contributors of those cases for allowing the *Synopsis* to use these cases in past and future editions.

ACKNOWLEDGMENTS

We sincerely appreciate our distinguished Editorial Assistant, Arya Shah, M.D., who helped us update much of the *Synopsis* and whose work there we include here.

We also wish to thank our colleagues and friends in our respective departments. This impressive group includes the staff and faculty at the Menninger Clinic and the Menninger Department of Psychiatry and Behavioral Sciences and the University of Central Florida.

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Our most tremendous thanks go to Benjamin and Virginia Sadock, who created an immensely valuable series of references. It is our honor to help continue in their tradition of scholarship, scientific pursuit, and humanism.



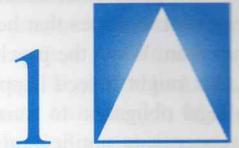
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Examination and Diagnosis of the Psychiatric Patient

▲ 1.1 The Adult Patient

PSYCHIATRIC INTERVIEW, HISTORY, AND MENTAL STATUS EXAMINATION

The psychiatric interview is the most crucial element in the evaluation and care of persons with mental illness. A significant purpose of the initial psychiatric interview is to obtain information that will establish a criteria-based diagnosis. This process, helpful in the prediction of the course of the illness and the prognosis, leads to treatment decisions. A well-conducted psychiatric interview provides a multidimensional understanding of the disorder's biopsychosocial elements. It provides the information necessary for the psychiatrist, in collaboration with the patient, to develop a person-centered treatment plan.

Equally important, the interview itself is often an essential part of the treatment process. From the very first moments of the encounter, the interview shapes the nature of the patient–physician relationship, which can have a profound influence on the outcome of treatment. The settings in which the psychiatric interview takes place include psychiatric inpatient units, medical nonpsychiatric inpatient units, emergency rooms, outpatient offices, nursing homes, other residential programs, and correctional facilities. The length of time for the interview, and its focus, will vary depending on the setting, the specific purpose of the interview, and other factors (including current competing demands for professional services).

Nevertheless, some basic principles and techniques are essential for all psychiatric interviews, and these will be the focus of this section. There are particular issues in the evaluation of children that will not be addressed. This section focuses on the psychiatric interview of adult patients.

General Principles

Agreement as to Process. At the beginning of the interview, the psychiatrist should introduce himself

and, depending on the circumstances, may need to identify why he or she is speaking with the patient. Unless implicit (the patient coming to the office), consent to proceed with the interview should be obtained, and the nature of the interaction and the approximate (or specific) amount of time for the interview should be stated. The patient should be encouraged to identify any elements of the process that he or she wishes to alter or add.

A crucial issue is whether the patient is, directly or indirectly, seeking the evaluation voluntarily or has been brought involuntarily for the assessment. This issue should be established before the interview begins, and this information will guide the interviewer, especially in the early stages of the process.

Privacy and Confidentiality. Issues concerning confidentiality are crucial in the evaluation/treatment process and may need to be discussed on multiple occasions. Health Insurance Portability and Accountability Act (HIPAA) regulations must be carefully followed, and the appropriate paperwork must be presented to the patient.

Confidentiality is an essential component of the patient–doctor relationship. The interviewer should make every attempt to ensure that others cannot overhear the content of the interview. Sometimes, in a hospital unit or other institutional setting, this may be difficult. If the patient is sharing a room with others, an attempt should be made to use a different place for the interview. If this is not feasible, the interviewer may need to avoid specific topics or indicate that these issues can be discussed later when privacy can be ensured. Generally, in the beginning, the interviewer should suggest that the content of the session(s) will remain confidential except for what needs to be shared with the referring physician or treatment team. Some evaluations, including forensic and disability evaluations, are less confidential, and what is discussed may be shared with others. In those cases, the interviewer should be explicit in stating that the session is not confidential and identify who will receive a report of the evaluation. This information should be carefully and thoroughly documented in the patient's record.