全国高等学校临床医学专业卫生部规划教材英文版

案例分析系列

精神病学

Case Files™ Psychiatry

第2版

原　　著　Toy • Klamen

中文主编　郝　伟

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案例分析系列

出 版 说 明

为贯彻教育部、卫生部关于加强双语教学的精神，配合全国各医学院校开展双语教学的需要以及适应以问题为中心的教学发展趋势，人民卫生出版社特引进了本套案例分析系列英文教材。该教材原版由美国麦格劳希尔教育出版集团出版，在美国各大医学院使用后反响良好。

书中通过剖析临床实例对相关的临床或基础知识进行回顾和复习，有助于医学生将医学基础知识和临床实践相结合。这种以问题为中心的学习(PBL)模式强调发挥学生主动思考的潜力，培养其自我学习能力。在编排上，作者有意将案例顺序随机化，目的是模拟真正的患者就医情景。为方便查询，书后附有以字母为序的案例排列索引。

加入中文编注后的案例分析系列基本保持原书风貌，并根据我国国内教学情况对重要知识点和词汇进行了点评和加注。本套教材语言叙述通俗、简练，既可加强读者对医学知识的理解，又可学习医学英语。

本系列首批教材包括12本：临床医学6本(内科学、外科学、妇产科学、儿科学、精神病学、急诊医学)，基础医学6本(解剖学、生理学、生物化学、微生物学、病理学、药理学)，将于2007年全部推出。

前　言

英文版案例分析系列《精神病学》是美国麦格劳希尔(McGraw-Hill)教育出版公司出版的教学用书。本书原文共分有四部分：第一部分为如何处理临床问题，包括如何接触病人、解决临床问题，使用诊断标准等，这是精神科医师的基本功。第二部分为精神疾病治疗部分，包括心理治疗和精神药物治疗，以问题为导向，深入浅出，简明扼要。第三部分为临床案例，揽括了几乎所有的精神疾病常见病例，是本书最出彩的部分，通过对不同临床实例的剖析来回顾和复习相关的临床知识，提出该临床实例的诊断及治疗意见，每一个病例后附有小结、讨论、练习题、答案、解释，并有对重点名词的定义，实用性很强。第四部分为案例目录。

本书改编后仍然基本保持原书风貌，只是根据我国国内教学情况删除了6个临床上不常见的案例。对重要知识点进行了加注，词汇部分着重专业词汇和部分难懂的公共词汇，同时在每一个案例后对整个案例进行点评。我们试图将每一个案例作为一个独立的单元进行加注和点评，因而每个案例的注释和解释会有各自不同的风格，在词汇和注释部分会有部分重复，目的是方便读者有针对性地阅读案例。

编著后的精神病学案例分析集是一本很好的中英文双语教科书，同时也是人民卫生出版社出版的五年制教科书《精神病学》第五、六版(郝伟主编)的配套教材，适用于不同英语水平层次的人群。编者们相信，无论是在读的本专业的医学生，还是精神病学专业的医务工作者，以及需要参加本专业晋升晋级考试的精神科专业人员，阅读本书对于提高自己的专业英语水平和临床专业水平定会大有裨益。

感谢人民卫生出版社国际出版中心的大力支持，使该书得以顺利出版；该工作得到了中南大学精神卫生研究所领导、同事的大力支持，在此一并表示真诚的感谢。

由于编者们的水平有限以及可能的理解偏差，译注、加注部分会有错误或者不妥，望专家、同道、读者不吝指正，使之日臻完善。

编　者

❖ INTRODUCTION

Mastering the cognitive knowledge within a field such as psychiatry is a formidable task. It is even more difficult to draw on that knowledge, procure and filter through the clinical and mental status data, develop a differential diagnosis, and finally form a rational treatment plan. To gain these skills, the student often learns best by directly interviewing patients, guided and instructed by experienced teachers and inspired toward self-directed, diligent reading. Clearly, there is no replacement for education at the patient's side. Unfortunately, clinical situations usually do not encompass the breadth of the specialty. Perhaps the best alternative is to prepare carefully crafted cases designed to simulate the clinical approach and decision making. In an attempt to achieve this goal, we have constructed a collection of clinical vignettes to teach diagnostic or therapeutic approaches relevant to psychiatry. Most importantly, the explanations for the cases emphasize mechanisms and underlying principles rather than merely rote questions and answers.

This book is organized for versatility: to allow the student "in a rush" to read the scenarios quickly and check the corresponding answers, as well as to provide more detailed information for the student who wants thought-provoking explanations. The answers are arranged from simple to complex: a summary of the pertinent points, the bare answers, an analysis of the case, an approach to the topic, a comprehension test at the end for reinforcement and emphasis. and a list of resources for further reading. The clinical vignettes are purposely presented in random order to simulate the way that real patients present to a practitioner. A listing of cases is included in Section Ⅳ to aid the student who desires to test their knowledge of a certain area or to review a topic, including the basic definitions. Finally, we intentionally did not primarily use a multiple-choice question(MCQ) format because clues(or distractors) are not available in the real world. Nevertheless, several MCQs are included at the end of each scenario to reinforce concepts or introduce related topics.

HOW TO GET THE MOST OUT OF THIS BOOK

Each case is designed to simulate a patient encounter by using open-ended questions. At times, the patient's complaint differs from the issue of greatest concern, and sometimes extraneous information is given. The answers are organized into four different parts.

PART I

1. A **Summary**: The salient aspects of the case are identified, filtering out extraneous

information. The student should formulate a summary of the case before looking at the answers. A comparison with the summation appearing in the answer will help improve the student's ability to focus on the important data while appropriately discarding irrelevant information, a fundamental skill required in clinical problem solving.

2. A **Straightforward Answer** to each open-ended question.
3. An **Analysis of the Case** consisting of two parts:
   a. **Obiectives**: A listing of the two or three main principles that are crucial for a practitioner in treating the patient. Again, the student is challenged to make "educated guesses" about the objectives of the case on initial review of the case scenario, which helps to sharpen his or her clinical and analytical skills.
   b. **Considerations**: A discussion of the relevant points and a brief approach to the specific patient.

PART Ⅱ

An Approach to the Disease Process consisting of two distinct parts:

a. **Definitions**: Terminology pertinent to the disease process.
b. **Clinical Approach**: A discussion of the approach to the clinical problem in general, including tables and figures.

PART Ⅲ

Comprehension Questions: Each case contains several MCQs that reinforce the material presented or introduce new and related concepts. Questions about material not found in the text are explained in the answers.

PART Ⅳ

Clinical Pearls: A listing of several clinically important points which are reiterated as a summation of the text and to allow for easy review, such as before an examination.

❖ CONTENTS

SECTION I

How to Approach Clinical Problems

PART 1. APPROACH TO THE PATIENT

It is a difficult transition from reading about patients with psychiatric disorders, and reading the diagnostic criteria from the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-Ⅳ*), to actually developing a psychiatric diagnosis for a patient. It requires the physician to understand the criteria and be able to sensitively elicit symptoms and signs from patients, many of whom have difficulty providing a clear history. The clinician must then put together the pieces of a puzzle in order to come up with the single best diagnosis for the patient. This process may require further information from the patient's family, additions to the medical and psychiatric history, careful observation of the patient, a physical examination, selected laboratory tests, and other diagnostic studies. Finally, and almost unique to the field of psychiatry, in order to better diagnose and treat their patients, physicians must be alert to and aware of the **unconscious conflicts**①, **anxieties**②, **and defenses**③ put into play by these individuals. Establishing rapport④ and a good therapeutic alliance with patients is critical to both their diagnosis and their treatment.

CLINICAL PEARL⑤

A patient's history is the single most important tool in establishing a diagnosis. Developing good rapport with patients is key to effective interviewing and thorough data gathering. Both the content (what the patient says and does not say) and the manner in which it is expressed (body language, topic shifting) are important.

History

1. Basic information:
   a. Identifying information includes name, age, marital status, gender, occupation, and language spoken other than English. Ethnic background and religion can also be included if they are pertinent.
   b. It is helpful to include the circumstances of the interview because they provide information about potentially important patient characteristics that may be relevant to the diagnosis, the prognosis⑥, or compliance⑦. Circumstances include where the interview was conducted (emergency setting, outpatient office, in leather restraints[注1]) and whether the episode reported was the first occurrence for the patient.

c. Sources of the information obtained and their reliability should be mentioned at the beginning of the psychiatric history.

2. Chief complaint: The chief complaint should be written exactly as the patient states it, no matter how bizarre[8]. For example, "The space aliens are attacking outside my garage so I came in for help." Other individuals accompanying the patient can then add their versions of why the patient is presenting currently, but the chief complaint stated in the patient's words helps with the initial formulation of a differential diagnosis. For example, if a patient comes in with a chief complaint about aliens, as noted above, one would immediately begin to consider diagnoses that have psychosis as a component and conduct the interview accordingly.

CLINICAL PEARL

❖ When recording a chief complaint in the patient's own words, put quotation marks around the patient's statements to indicate that they are indeed the patient's words, not the writer's:

❖ A 45-year-old woman comes to the emergency department with the chief complaint, "I know everyone is going to try to hurt me."

3. History of present illness (HPI): This information is **probably the most useful part of the history** in terms of **making a psychiatric diagnosis**. It should contain a **comprehensive**, **chronological picture** of the circumstances leading up to the encounter with the physician. It is important to include details such as when symptoms first appeared, in what order, and at what level of severity, as this information is critical in making the correct diagnosis. Relationships between psychological stressors and the appearance of psychiatric and/or physical symptoms should be carefully outlined. In addition, details of the history such as the use of drugs or alcohol, which are normally listed in the social history, should be put in the HPI if they are thought to make a significant contribution to the presenting symptoms.

4. Psychiatric history: The patient's previous encounters with psychiatrists and other mental health therapists should be listed in chronological order. Past psychiatric hospitalizations, the treatment received, and the length of stay should be recorded. Whether or not the patient has received psychotherapy, what kind, and for how long, are also important. Any pharmacotherapy received by the patient should be recorded, and details such as dosage, response, and compliance with the medication should be included. Any treatments with electroconvulsive therapy (ECT)[9]注2 should be noted as well, including the number of sessions and the as-

sociated effects.

5. Medical history: Any medical illnesses should be listed in this category along with the date of diagnosis. Hospitalizations and surgeries should also be included with their dates. Episodes of **head trauma**, **seizures**, **neurologic illnesses** or tumors, and positive assays for **human immunodeficiency virus** (**HIV**) are all pertinent to the psychiatric history.

6. Medications: A list of medications including their doses and their duration of use should be obtained. All medications, including over-the-counter[10], herbal[11], and prescribed, are relevant and should be delineated.

7. Allergies: A list of agents causing allergic reactions, including medications and environmental agents (dust, henna[12], etc) should be obtained. For each, it is important to describe what reaction actually occurred, such as a skin rash or difficulty breathing. Many patients who have had a dystonic[13] reaction to a medication consider it an allergy, although it is actually a side effect of the medication and not truly an allergy.

8. Family history: A brief statement about the patient's family history of psychiatric as well as medical disorders should be included. Listing each family member, their age, and their medical or psychiatric disorders is generally the easiest, clearest way to do this.

9. Social history:
   a. The **prenatal and perinatal history** of the patient is probably relevant for all young children brought to a psychiatrist. It may also be relevant in older children and/or adults if it involves birth defects or injuries.
   b. A **childhood history** is important when evaluating a child and may be important in evaluating an adult if it involves episodes of trauma, long-standing personal patterns, or problems with education. For a child, issues such as age of and/or difficulty in toilet training, behavioral problems, social relationships, cognitive and motor development, and emotional and physical problems should all be included.
   c. Occupational history, including military history.
   d. Marital and relationship history.
   e. Education history.
   f. Religion.
   g. Social history, including the nature of friendships and interests.
   h. Drug and alcohol history.
   i. Current living situation.

10. Review of systems: A systematic review should be performed with emphasis on common side effects of medications and common symptoms that might be associated with the chief complaint. For example, patients taking typical antipsychotic[14] agents[注3] (such as haloperidol[15]) might be asked about dry mouth, dry eyes, constipation, and urinary hesitancy. Patients with presumed panic disorder[16] might be questioned about cardiac symptoms such as palpitations[17] and chest pain or neurologic symptoms such as numbness and tingling.

Mental Status Examination[18]

The **mental status examination** comprises the **sum total** of the **physician's observations** of the patient at the time of the interview. Of note is that this examination can change from hour to hour, whereas the patient's history remains stable. The mental status examination includes impressions of the patient's **general appearance**, **mood**, **speech**, **actions**, **and thoughts**. Even a mute or uncooperative patient reveals a large amount of clinical information during the mental status examination.

CLINICAL PEARL

The mental status examination provides a snapshot of the patient's symptoms at the time of the interview. It may differ from the patient's history, which is what has happened to the patient **up until the time** of the interview. If a patient has thought about suicide for the past 3 weeks but during the interview says that he is not feeling suicidal while speaking with the psychiatrist, his **history** is considered **positive for suicidal ideation**[19] although the **thought content** section of the **mental status examination** is said to be **negative** for (current) **suicidal ideation.**

1. General description
   a. Appearance: A description of the patient's overall appearance should be recorded, including posture, poise, grooming[20], and clothing. Signs of anxiety should also be noted, such as wringing of hands, tense posture, clenched fists, or a wrinkled forehead.
   b. Behavior and psychomotor activity: Any bizarre posturing, abnormal movements, agitation, rigidity, or other physical characteristics should be described.
   c. Attitude toward examiner: The patient's attitude should be noted using terms such as "friendly," "hostile," "evasive," "guarded," or any of a host of descriptive adjectives.

2. Mood and affect
   a. **Mood**: the emotion (anger, depression, emptiness, guilt, etc) that underlies a person's perception of the world. Although mood can often be inferred throughout the course of an interview, it is best to ask the patient directly, "How has your mood been?" Mood should be **quantified[21] wherever possible**—a **scale from 1 to 10** is often used. For example, a person may rate his depression as 3 on a scale of 1 to 10 where 10 is the happiest he has ever felt.
   b. **Affect**: the person's emotional responsiveness during the examination as inferred from their expressions and behavior. In addition to the affect noted, the **range (variation) of the affect** during the interview, as well as its **congruency** with (consistency with) the stated mood, should be noted. A **constricted** affect means that there is little variation in facial expression or use of hands; a **blunted** or **flat affect** is even further reduced in range.
3. **Speech**: The physical characteristics of the patient's speech should be described. Notations as to the **rate, tone, volume, and rhythm** should be made. Impairments of speech, such as stuttering, should also be noted.
4. **Perception**: Hallucinations[22] and illusions[23] reported by the patient should be listed. The sensory system involved (tactile, gustatory, auditory, visual, or olfactory) should be indicated, as well as the content of the hallucination (eg, "It smells like burning rubber," "I hear two voices calling me bad names.") Of note is that whereas some clinicians use perception as a separate category, others combine this section with the thought content portion of the write-up/presentation.
5. **Thought process**: Thought process refers to the *form* of thinking or *how* a patient thinks. It does not refer specifically to *what* a person thinks, which is more appropriate to the thought content. In order of most logical to least logical, thought process can be described as **logical/coherent, circumstantial[24], tangential[25], flight of ideas[26], loose associations[27], and word salad[28]/incoherence**. Neologisms[29], punning[30], or thought blocking[31] also should be mentioned here.
6. **Thought content**: The actual thought content section should include **delusions[32] (fixed, false beliefs), paranoia[33], preoccupations[34], obsessions and compulsions[35], phobias[36], ideas of reference, poverty of content[37], and suicidal and homicidal ideation[38]**. Patients with suicidal or homicidal ideation should be asked whether, in addition to the presence of the ideation, they have a *plan* for carrying out the suicidal or homicidal act as well as about their *intent* to do so.
7. **Sensorium[39] and cognition**: This portion of the mental status examination asses-

ses **organic brain function**, **intelligence**, **capacity for abstract thought**[40], and **levels of insight and judgment**. The basic tests of sensorium and cognition are performed on every patient. Those whom the clinician suspects are suffering from an organic brain disorder can be tested with further cognitive tests beyond the scope of the basic mental status examination.

a. Consciousness[41]: Common descriptors of levels of consciousness include "alert," "somnolent[42]," "stuporous[43]," and "clouded consciousness[44]."

b. Orientation[45] and memory: The classic test of orientation is to discern the patient's ability to locate themself* in relation to person, place, and/or time. Any impairment usually occurs in this order as well (ie, a sense of time is usually impaired before a sense of place or person). Memory is divided into four areas: immediate, recent, recent past, and remote. **Immediate memory** is tested by asking a patient to **repeat numbers** after the examiner, in both forward and backward order. **Recent memory** is tested by asking a patient **what she ate for dinner the previous night** and asking if she remembers the examiner's name from the beginning of the interview. **Recent past memory** is tested by asking about news items publicized in the past several months, and **remote memory** is assessed by asking patients about their childhood. Note that information must be verified to be sure of its accuracy because confabulation (making up false answers when memory is impaired) may occur.

c. **Concentration**[46] **and attention: Subtracting serial 7's from 100** is a common way of testing concentration. Patients who are unable to do this because of educational deficiencies can be asked to subtract serial 3's from 100. Attention is tested by asking a patient to spell the word "world" forward and backward. The patient can also be asked to name five words that begin with a given letter.

d. Reading and writing: The patient should be instructed to read a given sentence and then do what the sentence asks, for example, "Turn this paper over when you have finished reading." The patient should also be asked to write a sentence. Examiners should be aware that illiteracy might impact a patient's ability to follow instructions during this part of the examination.

e. **Visuospatial ability**[47]: The patient is typically asked to **copy the face of a clock** and fill in the numbers and hands so that the clock shows the correct time. Images with **interlocking shapes or angles** can also be used—the patient is asked to copy them.

f. Abstract thought: Abstract thinking is the ability to deal with concepts. Can patients distinguish the similarities and differences between two given objects? Can patients understand and articulate the meaning of simple proverbs? (Be

aware that patients who are immigrants and have learned English as a second language may have problems with proverbs for this reason rather than because of a mental status disturbance.)

g. Information and intelligence: Answers to questions related to a general fund of knowledge(presidents of the United States, mayors of the city in which the mental status examination is conducted), vocabulary, and the ability to. solve problems are all factored in together to come up with an estimate of intelligence. A patient's educational status should of course be taken into account as well.

h. **Judgment**: During the course of the interview, the examiner should be able to get a good idea of the patient's ability to understand the likely outcomes of their behavior and whether or not this behavior can be influenced by knowledge of these outcomes. Having the patient predict what they would do in an imaginary scenario can sometimes help with this assessment. For example, what would the patient do if they found a stamped envelope lying on the ground?

i. **Insight**[48]: Insight is the degree to which a patient understands the nature and extent of their own illness. Patients may express a complete denial of their illness or progressive levels of insight into knowing that there is something wrong within them that needs to be addressed.

CLINICAL PEARL

Almost all of the mental status examination can be made by careful observation of the patient while obtaining a detailed, complete history. Only a few questions need to be addressed to the patient directly, for example, those regarding the presence of suicidal ideation and specific cognitive examination questions.

Physical Examination

The physical examination can be an important component of the assessment of a patient with a presumed psychiatric illness. Many physical illnesses masquerade[49] as psychiatric disorders, and vice versa. For example, a patient with **pancreatic cancer** may first present to a psychiatrist with symptoms of major **depression**. Thus an examiner should be alert to all of a patient's signs and symptoms, physical and mental, and be prepared to perform a physical examination, especially in an emergency department setting. Some patients may be too agitated or paranoid to undergo parts of the physical examination, but when possible, all elements should be completed.

1. General appearance: Cachetic[50] versus well-nourished, anxious versus calm,