PSYCHIATRY

FOR THE HOUSE OFFICER

SECOND EDITION

DAVID A. TOMB

WILLIAMS & WILKINS

Psychiatry for the House Officer

Second Edition

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Dedication

To my wife Jane and my daughter Collin
for time lost

Foreword

This book encompasses in distilled form much of what is clinically relevant in the field of modern psychiatry. A much larger book would have been easier to write. Condensing the vast amount of material covered in a readable, information-packed volume does credit to Dr. Tomb.

This volume should serve as an important resource for the medical student, the non-psychiatric house officer, and the practicing non-psychiatrist. It will be a very useful beginning text, in addition, for the psychiatric house officer since it discusses in a very few pages an enormous amount of specific medical/psychiatric information. For that reason it is suited admirably as a board review source.

This short text leaves the reader little doubt that the discipline of psychiatry has an extensive and well-founded body of "facts" which needs to be mastered if a physician is to treat his patients adequately. Dr. Tomb also clearly discusses the large number of patients with psychiatric problems who first present to the non-psychiatric physician and who need to be recognized and treated.

I expect that Psychiatry for the House Officer will become justifiably popular since it fills a need for a concise, factual volume for house officers and a trustworthy reference for busy practicing physicians.

Bernard I. Grosser, MD

About the Author

David A. Tomb, MD, an adult and child psychiatrist, is a faculty member in the Department of Psychiatry of the University of Utah School of Medicine. He was formerly the Clinical Director of the Utah State Hospital and the Director of Psychiatric Inpatient Services at the University of Utah Medical Center. He was graduated from the College of Wooster and the Pennsylvania State University Medical School. He is active in teaching and in the practice of adult and child psychiatry.

With a Foreword by Bernard I. Grosser, MD

Bernard I. Grosser, MD, is the chairman of the Department of Psychiatry of the University of Utah School of Medicine and is the Director of Clinical Services at the University of Utah Medical Center. He has been an active member of the International Society for Psychoneuroendocrinology and has published widely in the field of neuroendocrinology.

Preface to the Second Edition

Advances during the four years since publication of the first edition of this book have further clarified the various DSM-III disorders, suggested the proper clinical use of diagnostic tools such as the Dexamethasone Suppression Test (DST) and measures of urinary MHPG, and expanded the concepts of conditions such as bulimia and multiple personality. New psychopharmacologic agents have become available, as have refined psychotherapeutic techniques. In addition, psychiatry has experienced many other important refinements of fact and theory.

This new edition reflects these changes. I have made the information current and expanded and updated the references in each chapter. Throughout, I have attempted to capsulize the increasingly complex subject of modern psychiatry as briefly as possible. Spend the time thus saved with the real teachers: your patients.

David A. Tomb, MD
1984

Preface to the First Edition

Psychiatry is a field in ferment. There is much new information and there are several expanding areas of rapidly increasing sophistication. This book is an effort to present that information in a condensed but usable form. Since this book is designed for the non-psychiatric physician as well as the psychiatric resident, I have made an effort to emphasize medical/psychiatric correlations where they occur.

Throughout this book I have attempted to describe psychiatry in terms of the new official nomenclature, DSM-III, and each diagnosis is keyed to the identical diagnosis in DSM-III, both by number and page. To that extent, this book can also serve as an aid to diagnosis.

Although not meant to be comprehensive, I hope this manual gives a sense of the scope of current psychiatric knowledge. Psychiatry remains part art, part science. This book emphasizes the science while recognizing that it is frequently the art that heals. Armed with a core of facts, I hope that physicians will feel thoroughly comfortable when dealing with psychiatric patients, for that's where the action really is.

David A. Tomb, MD

Acknowledgments

This manual would have been quite different without the help of those who read the various parts of it. I particularly want to thank those physicians who had the temerity to read the majority of the manuscript in rough form: Doctors W. McMahon and L. King. I also am grateful to the following people for reading and criticizing selected chapters: Doctors P. Wender, B. Grosser, and L. Schmidt. Also my thanks go to those psychiatric residents who did battle with various chapters at various times.

Contents

Chapter 1

Psychiatric Classification

Psychiatric diagnosis has long been criticized as ambiguous and unreliable. Some diagnostic categories have been based on subjective, unverifiable intrapsychic phenomena, while others have been heterogeneously broad.

There are two responses to the familiar complaint of "why bother" using such imprecise tools.

1. There is a new, more reliable official classification scheme (DSM-III) which, although of uncertain validity, allows a more testable, scientific approach to mental disorders. This classification shall be used throughout this manual.
2. New and effective treatments for certain conditions (eg, some depressions, mania) make diagnostic specificity essential.

DSM-III

1980 saw the introduction of an innovative official psychiatric classification scheme in the USA: the 3rd edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III). This scheme asserts that there are a limited number of identifiable psychiatric disorders. DSM-III contains specific diagnostic criteria for each diagnosis. One matches facts from a particular patient's history and clinical presentation with those criteria from a likely diagnosis and if an adequate number are met, that diagnosis should be made. Each disorder has a unique set of diagnostic criteria. Multiple diagnoses are permitted and there are several specific categories of "atypical" disorders which allow for placement of the (often many) patients who have unusual presentations.

For example: A patient who (1) has been having auditory hallucinations which (2) have impaired his social relations and functioning at work (3) for at least 6

months and who is without signs of (4) a Major Affective Disorder or (5) an Organic Mental Disorder must be given the diagnosis of Schizophrenic Disorder. If the patient also has (6) a flat, incongruous, or silly affect and (7) frequent or constant incoherence, an additional diagnosis of Disorganized subtype must be made.

MULTIAXIAL CLASSIFICATION:

In addition to the operationally defined criteria, DSM-III also introduces a multiaxial system of classification. A patient is not fully classified until he is coded on each of five axes (although only the first three axes are needed for an official diagnosis):

- Axis I: The psychiatric syndrome (example above).
- Axis II: A personality disorder in adults; a Developmental Deviation in children (none may be present).
- Axis III: Physical disorders (none may be present).
- Axis IV: A severity rating of psychosocial stress during the past year.
- Axis V: A measure of the highest functioning reached over the preceding year.

The specific rating scales for each axis are included in the text of DSM-III.

FUNDAMENTAL PSYCHIATRIC CONCEPTS

Psychiatric pathology is organized into several broad categories.

PSYCHOSIS: A general term referring to a major mental disorder having a marked impairment of:

- a sense of reality, and
- the ability to communicate, and/or
- emotional awareness and control, and/or
- cognitive abilities

which lead (1) to an inability to maintain interpersonal relations and (2) to compromised daily functioning. The principle types of psychotic disorders are:

1. Schizophrenic, Paranoid, and Schizoaffective Disorders
2. Schizophreniform Disorder and Brief Reactive Psychosis
3. Some Major Affective Disorders
4. Severe Organic Brain Syndromes