The Psychiatric Interview for Differential Diagnosis

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Foreword

This book fills a substantial gap in contemporary psychiatry and is written by two researchers and clinicians who have in-depth knowledge and scholarship in psychopathology. Psychiatry is currently in a state of profound crisis, from time to time acknowledged in major journals (Andreasen 2007; Kleinman 2012).

This crisis contains several independent components, first the diagnostic manuals have bred ever new categories and this proliferation has resulted in approximately 400 categories in the DSM and ICD systems. We have no etiological knowledge of the vast majority of these categories and we do not know much about their treatment. It is even doubtful if they all should be the matter of psychiatry (Ghaemi 2012). As it has been demonstrated by a Danish epidemiological study (Munk-Jorgensen et al. 2010), clinicians would be happy with approximately 20 categories. Choosing the most relevant diagnosis (differential diagnosis) between 400 categories is, of course, a matter for a computer and not for a human being.

The second component of the crisis is an increasing gap between a brilliant progress in basic neuroscience and its complete lack of consequences for clinical psychiatry (Hyman 2010). Clinical psychiatry is in a state of stagnation and new inventions and the treatment innovations come from people working on the ground and not from psychiatric academia.

The third component of importance and perhaps the root problem of psychiatry is the nature of the diagnostic system itself. In the preparations for DSM-III, the idea was to define its diagnostic categories by a prototypical narrative description supplemented by a list of selected symptoms that clinicians were obliged to complete. In the final production of DSM-III, the prototypes were abandoned and diagnoses defined by a sufficient number of symptoms from specific lists. It was naively believed that symptoms could be defined in a so-called operational way (Parnas and Bovet 2015). In these systems, the symptoms are considered as well-demarcated, mutually independent, thing-like objects, which can be unproblematically registered and quantified. The specific lists of symptoms for each diagnostic category were limited to a number of symptoms believed to be characteristic, as “gate keepers” to diagnosis. This entailed the disastrous consequence that the listed criteria came to be considered as the exhaustive description of the category in question, in other words, vast domains of psychiatry has gone into oblivion because psychiatric textbooks typically limit their psychopathological section to reprinting the DSM criteria.

The symptoms, which are shared by different disorders, were eliminated from the diagnostic systems in order to sharpen the boundaries of the categories. Thus, for example, it is often a novelty for a psychiatrist to hear that anxiety is a common feature of beginning schizophrenia.

These epistemological deformations of the object of psychiatry (symptoms and signs) have undoubtedly contributed to a lack of research progress and to a situation where the diagnostic process is basically reduced to an “associative event”: when a patient presents with a complaint of being down, it is likely that he will be diagnosed with depression, and, if he says that he cuts himself, it is likely that he will receive the diagnosis of borderline. We also observe epidemics of certain mental disorders such as ADHD, autistic spectrum, etc., epidemics reflective of the problems of differential diagnosis in the operational systems (Parnas 2015).

A separate but closely related problem is that of interviewing the patient. We have empirically demonstrated that a fully structured interview is an absurdity (Nordgaard et al. 2012), and we have provided a detailed theoretical explanation in a separate paper (Nordgaard et al. 2013). The problem put very simple is that psychiatrists are not trained in conducting a psychiatric interview in a way that is phenomenologically correct, i.e., that allows the symptoms to emerge and articulate themselves in a quasi-natural conversation between the patient and the doctor. This volume describes certain basics of the psychiatric interview that have to be adopted in order to conduct an interview, which is maximally informative.

The symptom is not an isolated piece but typically depends on the context and larger wholes to which it belongs (Nordgaard et al. 2013). This book attempts to restore the basic knowledge of psychopathology and of the epistemic process involved in making psychiatric diagnoses. It provides a useful catalog of psychopathological descriptions based on a massive body of classic and modern psychopathological literature. It also restores a prototypical approach to diagnosis, explained very simple: when we see a patient we see him as a certain person in a specific context; if it is a 40-year-old male, still living with his mother, only leaving the apartment at night, and complains of “feeling down” it is unlikely that the cardinal problem is an affective disorder. These processes of typification and their relevance for diagnoses are explicated in detail in this book.

This volume is primarily addressing clinical psychiatrists and psychologists, psychiatric residents, and people involved in psychiatric research. It is also helpful to psychiatric nursing staff and other paramedical personnel involved in the treatment of psychiatric patients.

Copenhagen, Denmark
2016

Josef Parnas

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