SAMPLE CHAPTER FROM:

Images of Mental Illness in Central Asia:

A Casebook with Commentaries

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Introduction

ORIGIN AND PURPOSES OF THE PROJECT

This casebook has its origins in talks between two of the editors (N. Sartorius and V. Solojenkin) late in 1998. At that time Professor Solojenkin organized a meeting of representatives of psychiatric societies of several countries in Central Asia with the president of the World Psychiatric Association, who at the time was Professor Sartorius. Numerous issues were discussed, but three seemed to be of particular interest to the participants. The first was the education of psychiatrists in countries of Central Asia. Previously, they all trained in Russia, and their contacts with the rest of the world were limited or nonexistent. Now, the participants felt, the situation was different and it was important to find ways to improve the relationship with psychiatry elsewhere — through joint projects, exchange of literature and other means. An essential prerogative for such exchanges of experience and communication between psychiatrists was that they have a common professional and scientific language ranging from concepts and criteria for diagnosis to the interpretation of the evidence and experience in other parts of the world.

A second priority of the participants was their feeling that psychiatrists in other parts of the world regarded psychiatrists in Central Asia as less well trained and generally not as apt to make modern diagnoses as their colleagues in Western Europe or Russia or other countries in which they received their training. The third issue that appeared to be of general interest was treatment, and the differences that might exist between clinical psychiatric practice in Central Asia and elsewhere.

It was decided that the best way to deal with these three issues was to discuss the diagnosis and treatment of patients seen in Central Asia with the aim of determining whether there are differences in the way psychiatrists make their diagnoses and prescribe treatment in Central Asia and in other countries. Such an examination of real cases might

also provide an opportunity to demonstrate that the psychiatrists in Central Asia were using the same rules and ways of making their diagnoses and that their competence to do so was the same as that of their colleagues in other countries. Psychiatrists in the countries concerned all learned the same broadly descriptive style of clinical psychiatry during their medical education, and are already familiar with the *10th Revision of the International Classification of Mental and Behavioural Disorders* [ICD-10 Chapter V(F)] (*1*), so it was thought that a useful exchange of opinions would be possible.

It was originally hoped that the assessments would be presented and jointly debated during a meeting bringing together experts from the three groups of countries. Unfortunately, financial constraints and the practical difficulties of bringing participants together for a sufficient period of time made it necessary to rely instead on circulation of detailed case histories, without a meeting. The detailed clinical case histories were prepared by psychiatrists in Kyrgyzstan, Kazakhstan, Tajikistan and Uzbekistan; in the rest of this volume these countries are subsequently referred to as the Central Asian group of countries. The case histories were then circulated by the editors to psychiatrists in Eastern and Western European countries for further assessment and comments. The Eastern European countries concerned are Belarus, Georgia, Russia, and the Ukraine. The Western European countries are Denmark, Germany, Italy, Switzerland and the United Kingdom. The names of the assessors in all these countries can be found in the Acknowledgements section.

This publication is called a casebook, but it has a very different style and purpose from the casebooks already available for ICD-10 V(F) and the *Diagnostic and Statistical Manual of Mental Disorders,* fourth edition (DSM-IV) (*2–4*). These are designed to demonstrate how the classifications should be used, and the case histories contain clear descriptions of a sufficient number of the criteria required to arrive at a firm diagnosis of the disorders being illustrated. In the present project, the authors of the case histories were asked to follow their usual clinical procedures and were not requested to use special checklists of diagnostic criteria when interviewing patients on whom the case histories are based. This means that, although the case histories contain enough clinical and biographical information for ordinary clinical purposes, there are some gaps or incomplete items of information in terms

of the ideal requirements for diagnoses using ICD-10 V(F) (or any other set of diagnostic criteria). There are therefore some typical and realistic problems for subsequent diagnostic discussions, of the same sort that are encountered in everyday clinical work and case conferences.

We hope that this casebook goes some way towards satisfying the three priorities noted above. It is presented as an educational tool that can be used to encourage psychiatrists to use the same professional language when they describe cases that they see and treat; it clearly demonstrates that psychiatrists from Central Asia can use the same diagnostic and classificatory system as do their colleagues elsewhere; and it illustrates some of the differences in the treatments used for mental disorders by psychiatrists in Central Asia and those in other countries. This publication also highlights one of the underlying educational purposes of the project, which is to encourage the idea that the best interests of the patients will be served by having, whenever possible, a constructive debate about different options for diagnosis and treatment.

There is an interesting historical precedent for the use of detailed clinical case histories in collaborative international studies. In 1968, during the course of 'Programme A' set out by the World Health Organization (WHO) Geneva as part of the group of activities designed to culminate in the production of an internationally acceptable classification of mental disorders, a case history exercise of a design broadly similar to the one described here was carried out (*5*). It was regarded as a success by the participants, and its low cost was one of the features that led to the choice of a similar design for this present project.

Chapter 1

DESIGN OF THE PROJECT

The case histories

Twenty clinical case histories were written by psychiatrists in the Central Asian countries of Kyrgyzstan, Kazakhstan, Uzbekistan and Tajikistan as the basis for this exercise. These were based on real patients taken from the everyday clinical practice of psychiatrists in these countries, but a few non-clinical changes were made to remove the risk of personal identification of the patients. The patients on whom the case histories are based were selected to reflect the main sections of ICD-10 V(F).

For the purposes of this first exercise, it was decided to limit the choice of case histories to general adult psychiatry. Additional case histories illustrating the psychiatry of the elderly, children and adolescents, and persons with learning difficulties (developmental psychiatry) could form the basis of additional future exercises, should this first one be successful.

Translation and editing

The case histories were written in Russian. After translation into English by professional translators associated with the Geneva Initiative organization (who were not psychiatrists, and most of whom did not have English as their first language), they were circulated to the collaborators in the Eastern European and Western European countries. Some small editing changes were made to the English for the purposes of final publication in this volume, but the editors are aware that the text of a number of the case histories still contains some sentences that are not of the highest standard of English. Similarly, the names of some medications are spelt in a non-standard manner. Nevertheless, the meaning is always clear (and none of the assessors complained that they were hampered by these minor irregularities). These minor defi-

ciencies have been left in this final version because this is what was sent out to the assessors. In the early stages of the project there was neither the time nor the resources for the back-and-forth queries that would have been necessary to produce the highest possible standard of English. Also, the editors believe that it is important for the reader to see exactly what the assessors based their comments and conclusions on, in case they wish to use any of the case histories in local teaching sessions and discussions.

Recording of diagnoses, treatment, management and prognosis

The case histories were divided into two parts. The first contained the information in the case histories up to the time when the clinician in charge of the patient had finished the examination and investigation of the patient, but had not recorded the choice of diagnosis and treatment. The second part contained the diagnosis, treatment and management chosen by the clinician in charge of the patient, and information about subsequent progress and follow-up.

The collaborating assessors

Experienced clinical psychiatrists were then recruited to act as assessors of the case histories in the Eastern European countries of Ukraine, Belarus, Georgia and Russia (Moscow and Yaroslavl), and in the Western European countries of Denmark, Germany, Switzerland and the United Kingdom.

The collaborating assessors were initially sent the first part of the case history only (this meant that they did not know the diagnoses, treatment and management chosen by the clinicians in charge of the patients), and were asked to record their own suggestions for diagnosis, treatment, management and prognosis on Form 1 (see Appendix 5 for Forms 1 and 2), using ICD-10 V(F).

Form 1 provides for a main diagnosis and, if required, subsidiary and alternative diagnoses. (These are defined in the Appendix). ‘Treatment’ refers to named specific therapeutic procedures, either chemical or psychological, and ‘management’ refers to the general setting (such as outpatient, inpatient or day patient) in which the specific treatment is

given. When the completed Form 1 had been returned, the assessors were then sent the second part of the case history and Form 2, on which they indicated whether they wished to change their opinions.

Status of different diagnostic statements

It is important to remember that the purpose of this project is to encourage the exchange of opinions about clinical issues. It is neither a formal reliability study of ICD-10 V(F) nor a systematic study of the diagnostic habits of any particular group of psychiatrists.

For general purposes, the case histories are identified and arranged by the 'original' diagnosis chosen by the person who wrote them, even though in some instances several of the assessors chose other categories. The term 'case history' is used throughout, rather than 'case' or 'patient'. This is because however much detail is put into a case history, it can never be a complete description of, or substitute for, all that is relevant to the life and times of the real person and family that are the basis of the written case history.

For purposes of discussion and identification of the case histories, the diagnosis made by the clinician in charge of the patient is usually used. Most of the time this agrees with a majority choice of the assessors. A consensus editors' diagnosis is given at the end of the discussion of each case history. For simplicity, in the majority of instances this is limited to an Editors' Main Diagnosis.

Although space was provided on Form 1 for assessors to record conditions outside Chapter V(F), many did not do so even in the case histories where other conditions were obvious. When assesors did use such codes, the variation between them was such that it is not possible to summarise the results usefully. This variable response can be expected to be quite common in many countries unless specific instructions are provided. A note on this problem in included in Appendix 2.

The commentaries on the case histories

The final stage of the project was to enrol an additional five pairs of experienced clinicians in West European countries who were willing to comment on the opinions of the diagnosis and treatment already obtained regarding the case histories. They were also asked to make

further comments about what might be learned from each case history. Each pair of commentators was sent four case histories plus a table of the diagnoses already made by the collaborating assessors. They were asked to write a commentary with the following sections:

(i) A brief *summary* of about 10–15 lines, indicating the main points of interest in the case history which should stimulate discussion.

(ii) A *discussion* of whatever points of interest they chose to raise. These points might concern the clinical problems of managing and treating the patients on whom the case histories were based, or about problems inherent in the concepts of the disorders being diagnosed, or problems caused by the way the disorders are arranged in the classification itself.

(iii) Any *suggestions* about future clinical research relevant to this type of clinical problem.

There was considerable variation in the length and style of the first drafts of these commentaries received by the editors, but there has been no attempt by the editors to try to make them more similar. This variation simply reflects the nature of discussion between experts, who inevitably choose to comment upon what they themselves see as important.

The editors provided the commentators with the full text of the case histories, in exactly the same version as that used by the assessors.

For the convenience of readers who may not have immediate access to the official WHO publications on ICD-10 V(F), an extract from the *Clinical Descriptions and Diagnostic Guidelines* (CDDG) of ICD-10 V(F) for the disorders most relevant to the discussions of the case histories has also been included at the end of each chapter (*1*). However, the editors recommend strongly that, in view of its international origins and purposes, a copy of the CDDG to ICD10 V(F) should be purchased and studied as a part of post-graduate psychiatric training in all countries. This is in addition to any other diagnostic systems whose use may be required nationally or locally. A study of the differences between any national or local diagnostic systems and ICD-10 should be well worthwhile, so long as special attention is paid to the reasons for any differences. (In addition to the CDDG, the ICD-10 *Criteria for Research* (*6*) are also available, as well as two pocket books giving gen-

eral guidance and explanations about ICD-10 V(F) (*7, 8*). Psychiatrists will also be interested in the shorter classification prepared by WHO Geneva for use in primary care (*9*).

In the chapters that follow, the case histories are grouped together according to the main sections of ICD-10 V(F), together with tables showing the diagnoses given by assessors for those case histories. If the assessors are regarded as three groups (Central Asian, Eastern European and Western European), some differences emerge in opinions about treatment, management and prognosis which are discussed briefly in later chapters.