Psychiatry 5th year

Chapter 2: Examination & Diagnosis

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- History and Mental Status Examination
- Interviewing Skills
- Diagnosis and Classification
- Diagnostic Testing

History and Mental Status Examination

- Interviewing
- Taking the History
- Mental Status Examination
- Bedside Cognitive Testing

INTERVIEWING

- **Making the Patient Comfortable.**
- The initial interview is of utmost importance to the psychiatrist. With practice, you will develop your own style and learn how to adapt the interview to the individual patient.
- In general, start the interview by asking open-ended questions. Carefully note how the patient responds, as this is critical information for the mental status exam.
- Consider preparing for the interview by writing down the subheadings of the exam.
- Find a safe and private area to conduct the interview.
- Use closed-ended questions to obtain the remaining pertinent information.
- During the First interview, the psychiatrist must establish a meaningful rapport with the patient in order to get accurate and pertinent information.

INTERVIEWING

- This requires that the questions be asked in a quiet, comfortable setting so that the patient is at ease.
- The patient should feel that the psychiatrist is interested, nonjudgmental, and compassionate.
- In psychiatry, the history is the most important factor in formulating a diagnosis and treatment plan.
- **WARDS TIP:** If you are seeing the patient in the ER, make sure to ask how they got to the ER (police, bus, walk-in, family member) and look to see what time they were triaged. For all initial evaluations, ask why the patient is seeking treatment today as opposed to any other day.
- **WARDS TIP:** The history of present illness (HPI) should include information about the current episode, including symptoms, duration, context, stressors, and impairment in function

Date and Location:

Identifying Patient Data:

Chief Complaint:

History of Present Illness:

Past Psychiatric History:

First contact:

Diagnosis:

Prior hospitalizations:

Suicide attempts:

Outpatient treatment:

Med trials:

Substance History:

Smoking:

Family Psychiatric History:

Legal History:

Past Medical History:

Allergies:

Current Meds:

Developmental History:

Relationships (children/marital status):

Education:

Work History:

Military History:

Housing:

Income:

Religion:

FIGURE 2-1. Psychiatric history outline.

TAKING THE HISTORY

- **Identifying data:** The patient's name, preferred gender, age, marital status.
- **Chief complaint** (use the patient's own words): If called as a consultant, list reason for the consult.
- **Sources of information.**
- **History of present illness (HPI):**
  - **The 4 Ps:** The patient's psychosocial and environmental conditions predisposing to, precipitating, perpetuating, and protecting against the current episode.
  - **The patient's support system** (whom the patient lives with, distance and level of contact with friends and relatives).
  - **Neurovegetative symptoms** (quality of sleep, appetite, energy, psychomotor retardation/activation, concentration).
  - **Suicidal ideation/homicidal ideation.**
  - **How work and relationship have been affected [DSM-5]**
  - **Psychotic symptoms** (e.g., auditory and visual hallucinations, delusions).
  - **Establish a baseline of mental health:** Patient's level of functioning when "well". Goals (outpatient setting).

TAKING THE HISTORY

- **Past psychiatric history** (include as applicable: history of suicide attempts, history of self-harm [e.g., cutting, burning oneself], information about previous episodes, other psychiatric disorders in remission, medication trials, past psychiatric hospitalizations, current outpatient psychiatrist).
- **Substance history** (age of first use, amount and route of use, history of withdrawal/delirium tremens (DTs), longest period of sobriety, history of intravenous drug use, participation in outpatient or inpatient drug rehab programs).
- **Medical history** (ask specifically about head trauma, seizures, pregnancy status).
- **Family psychiatric and medical history** (include substance use, suicides, and response to specific psychotropic agents as patient may respond similarly).
- **Medications** (ask about supplements and over-the-counter [OTC] medications, as well as compliance).
- **Allergies:** Clarify if it was a true allergy or an adverse drug event (e.g., abdominal pain).

TAKING THE HISTORY

- **Developmental/Social history:** Achieved developmental milestones on time, friends in school, history of trauma or abuse, performance academically. Also include income source, employment, education, place of residence, who they live with, number of children, support system, religious affiliation and beliefs, legal history, and amount of exercise.

- **WARDS TIP:** When taking a substance history, remember to ask about caffeine and nicotine use. If a heavy smoker is hospitalized and does not have access to nicotine replacement therapy, nicotine withdrawal may cause anxiety and agitation.

- **WARDS TIP:** Psychomotor retardation, which refers to the slowness of voluntary and involuntary movements, may also be referred to as hypokinesia or bradykinesia. The term akinesia is used in extreme cases where absence of movement is observed.

Q: What OTC medication would be important to ask and document in a patient with bipolar disorder taking Lithium?

A: (NSAIDs) as they can ↑ lithium concentrations

MENTAL STATUS EXAMINATION

This is analogous to performing a physical exam in other areas of medicine. It is the nuts and bolts of the psychiatric exam. It should describe the patient in as much detail as possible. **The mental status exam assesses the following:**

- **Appearance/Behavior**
- **Speech**
- **Mood/Affect**
- **Thought process**
- **Thought content**
- **Perceptual disturbances**
- **Cognition**
- **Insight**
- **Judgment/Impulse control the mental status exam tells only about the mental status at that moment; it can change every hour or every day, etc.**

Appearance/Behavior

Appearance

- Gender
- Age (looks older/younger than stated age).
- Type of clothing, hygiene (including smelling of alcohol, urine, feces).
- Posture, grooming.
- physical abnormalities, tattoos, body piercings.
- ***Take specific notice of the following, which may be clues for possible diagnoses:***
  - **Pupil size:** Drug intoxication/withdrawal.
  - **Bruises in hidden areas:** suspicion for abuse.
  - **Needle marks/tracks:** Drug use.
  - **Eroding of tooth enamel:** Eating disorders (from vomiting).
  - **Superficial cuts on arms:** Self-harm.

Behavior

- Attitude (cooperative, seductive, flattering, charming, eager to please, entitled, controlling, uncooperative, hostile, guarded, critical, antagonistic, childish),
- Positioning (sitting, standing), mannerisms.
- Tics.
- eye contact.
- Activity level.
- Psychomotor retardation/activation.
- Akathisia,
- Automatisms.
- Catatonia, Choreoathetoid movements, Compulsions,
- Dystonias, Tremor.

Speech

- Rate (pressured, slowed, regular),
- Rhythm (i.e., prosody),
- Articulation (dysarthria, stuttering),
- Accent/Dialect, volume/modulation (loudness or softness),
- Tone,
- Long or short latency of speech,
- Quantity of speech (hyperverbal, paucity of speech).

Q: What is pressured speech?

A: Speech that is usually uninterruptible with the patient compelled to continue speaking.

Mood

Mood is the emotion that the patient tells you they feel, often in quotations.

WARDS TIP: To assess mood, ask, "How are you feeling today?" It can also be helpful to have patients rate their stated mood on a scale of 1–10.

Affect

Affect is an assessment of how the patient's mood appears to the examiner, including the amount and range of emotional expression.

It is described with the following dimensions:

- **Type of affect:** Euthymic, euphoric, neutral, dysphoric.

- **Range describes the depth and range of the feelings shown.**

Parameters: Flat (none) - Blunted (shallow) - Constricted (limited) - Full (average) - intense (more than normal).

- **Motility describes how quickly a person appears to shift emotional states.**

Parameters: Sluggish - Supple - Labile.

- **Appropriateness to content** describes whether the affect is congruent with the subject of conversation or stated mood.

Parameters: Appropriate - Not appropriate.

KEY FACT: Automatisms are spontaneous, involuntary movements that occur during an altered state of consciousness and can range from purposeful to disorganized.

Q: What is a flat affect? A patient who remains expressionless and monotone even when discussing extremely sad or happy moments in their life.

KEY FACT: An example of inappropriate affect is a patient's laughing when being told they have a serious illness.

A patient who is laughing one second and crying the next has a ***labile affect***.

Thought Process

The patient's form of thinking—how they use language and put ideas together. It describes whether the patient's thoughts are logical, meaningful, and goal directed. It does not comment on what the patient thinks, only how the patient expresses their thoughts.

- **Logical/Linear/Goal-directed:** Answers to questions and conversation clear and follows a logical sequence.
- **Circumstantiality** is when the point of the conversation is eventually reached but with overinclusion of trivial or irrelevant details.

Examples of thought disorders include:

- **Tangentiality:** Can follow conversation but point never reached or question never answered.
- **Loosening of associations:** No logical connection from one thought to another.
- **Flight of ideas:** Thoughts change abruptly from one idea to another, often based on understandable associations or distracting stimuli; usually accompanied by rapid/pressured speech.
- **Neologisms:** Made-up words.
- **Word salad:** Incoherent collection of words.
- **Clang associations:** Word connections due to phonetics rather than actual meaning. "My car is red. I've been in bed. It hurts my head."
- **Thought blocking:** Abrupt cessation of communication before the idea is finished.

Thought Content

Describes the types of ideas expressed by the patient.

Examples of disorders:

- **Poverty of thought versus overabundance:** Too few versus too many ideas expressed.
- **Delusions:** Fixed, false beliefs that are not shared by the person's culture and remain despite evidence to the contrary. Delusions are classi"ed as bizarre (impossible to be true) or nonbizarre (at least possible).
- **Suicidal and homicidal ideation:** Ask if the patient feels like harming themself or others. Identify if the plan is well formulated. Ask if the patient has an intent (i.e., if released right now, would they kill themself or harm others?). Ask if the patient has means to kill themself ("rearms in the house/ multiple prescription bottles).
- **Phobias:** Persistent, irrational fears.
- **Obsessions:** Repetitive, intrusive thoughts **(The following question can help screen for obsessions: Do you think and/or worry about checking, cleaning, or counting on a repetitive basis?)**

Examples of delusions:

- **Grandeur:** Belief that one has special powers or is someone important (Jesus, President).
- **Paranoid:** Belief that one is being persecuted.
- **Reference:** Belief that some event is uniquely related to patient (e.g., a TV show character is sending messages to patient).
- **Thought broadcasting:** Belief that one's thoughts can be heard by others.
- **Religious:** Conventional beliefs exaggerated (e.g., God wants me to be the Messiah).
- **Somatic:** False belief concerning body image (e.g., I have cancer).

Perceptual Disturbances

Hallucinations: **Sensory perceptions that occur in the absence of an actual stimulus.**

- **Describe the sensory modality:** Auditory (most common), visual, gustatory, olfactory, or tactile.
- **Describe the details** (e.g., auditory hallucinations may be ringing, humming, whispers, or voices speaking clear words). *Command auditory hallucinations* are voices that instruct the patient to do something.
- Ask if the **hallucination is experienced** only while falling asleep (hypnagogic hallucination) or upon awakening (hypnopompic hallucination).
- **WARDS TIP:** Alcoholic hallucinosis refers to hallucinations (usually auditory, although visual and tactile may occur) that occur either during or after a period of heavy alcohol consumption. Patients usually are aware that these hallucinations are not real. In contrast to DTs, there is no clouding of sensorium and vital signs are normal.

Q: What type of hallucinations are an important risk factor for suicide or homicide?

A: Command hallucinations (auditory hallucinations that instruct a patient to harm themselves or others).

Illusions: Inaccurate perception of existing sensory stimuli (e.g., wall appears as if it's moving).

Derealization/Depersonalization: The experience of feeling detached from one's surroundings/mental processes.

Cognition

- **Consciousness:** Patient's level of awareness; possible range includes: alert— drowsy—lethargic—stuporous—comatose.
- **Orientation:** To person, place, and time.
- **Calculation:** Ability to add/subtract.
- **Memory:**

Immediate (registration): Dependent on attention/concentration and can be tested by asking a patient to repeat several digits or words.

Recent (short-term memory): Events within the past few minutes, hours, or days.

Remote memory (long-term memory).

- **Fund of knowledge:** Level of knowledge in the context of the patient's culture and education (e.g., Who is the president? Who was Picasso?).
- **Attention/Concentration:** Ability to subtract serial 7s from 100 or to spell "world" backward.
- **Reading/Writing:** Simple sentences (must make sure the patient is literate first).
- **Abstract concepts:** Ability to explain similarities between objects and understand the meaning of simple proverbs

Insight

- Insight is the patient's level of awareness and understanding of their problem.
- Problems with insight include complete denial of illness or blaming it on some thing else.
- Insight can be described as full, partial/limited, or minimal

Judgment

- Judgment is the patient's ability to understand the outcome of their actions and use this awareness in decision making;
- it is best determined from information from the HPI and recent behavior (e.g., how a patient was brought to treatment or medication compliance).
- Judgment can be described as excellent, good, fair, or poor.

Mrs. W is a 52-year-old female who arrives at the emergency room reporting that her deceased husband of 25 years told her that he would be waiting for her there. To meet him, she drove nonstop for 22 hours from a nearby state. She claims that her husband is a famous preacher and that she, too, has a mission from God. Although she does not specify the details of her mission, she says that she was given the ability to stop time until her mission is completed. She reports experiencing high levels of energy despite not sleeping for 22 hours. She also reports that she has a history of psychiatric hospitalizations but refuses to provide further information.

While obtaining her history you perform a mental status exam. Her **appearance** is that of a woman who looks older than her stated age. She is obese and unkempt. There is no evidence of tattoos or piercings. She has tousled hair and is dressed in a mismatched flowered skirt and a red T-shirt. Upon her arrival at the emergency room, her **behavior** is demanding, as she insists that you let her husband know that she has arrived. She then becomes irate and proceeds to yell, banging her head against the wall. She screams, "Stop hiding him from me!" She is uncooperative with redirection and is guarded during the remainder of the interview. Her eye contact is poor as she is looking around the room. Her **psychomotor activity** is agitated. Her **speech** is loud and pressured, with a foreign accent.

She reports that her **mood** is "angry," and her **affect** as observed during the interview is labile and irritable.

Her **thought process** includes flight of ideas. Her **thought content** is significant for delusions of grandeur and thought broadcasting, as evidenced by her refusing to answer most questions claiming that you are able to know what she is thinking. She denies suicidal or homicidal ideation. She expresses **disturbances in perception** as she admits to frequent auditory hallucinations without commands.

She is uncooperative with formal **cognitive** testing, but you notice that she is oriented to place and person. However, she erroneously states that it is 2005. Her attention and concentration are notably impaired, as she appears distracted and frequently needs questions repeated. Her **insight**, **judgment, and impulse control** are determined to be poor.

You decide to admit Mrs. W to the inpatient psychiatric unit in order to allow for comprehensive diagnostic evaluation, the opportunity to obtain collateral information from her prior hospitalizations, safety monitoring, medical workup for possible reversible causes of her symptoms, and psychopharmacological treatment.

BEDSIDE COGNITIVE TESTING

The Montreal Cognitive Assessment (MoCA)

- The MoCA is a simple, brief test used to assess gross cognitive functioning. The test and its instructions are available online (Figure 2-2).

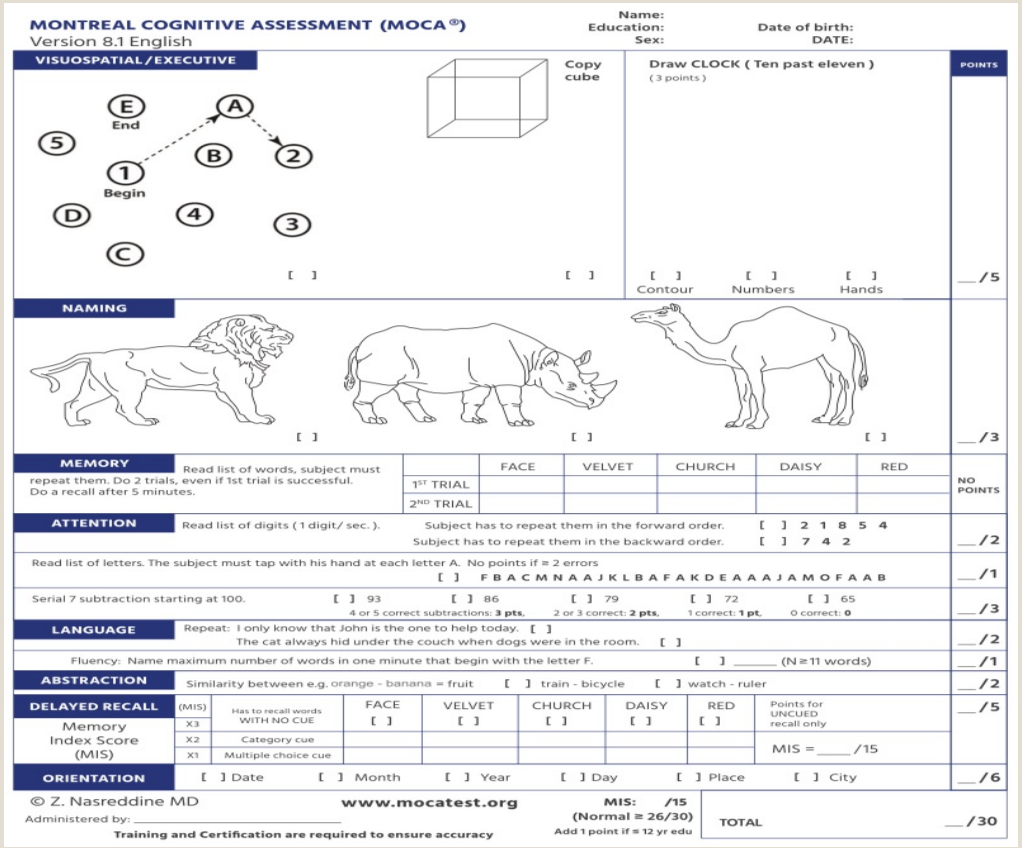
The areas tested include:

Orientation (to person, place, and time).

- *Memory* (immediate—repeating 5 words; and recent—recalling the words 5 minutes later).
- *Attention* (serial 7s, tapping hand with certain letters, repeating digits).
- *Language* (naming, repetition, frequency).
- *Abstraction* (e.g., saying how a "train" and "bicycle" are alike).
- *Visuospatial ability/executive functioning* (trail making task, cube copying, clock drawing)

BEDSIDE COGNITIVE TESTING

The Montreal Cognitive Assessment (MoCA)



MONTREAL COGNITIVE ASSESSMENT (MOCA®) Name: Education: Date of birth: Sex: DATE:

Version 8.1 English

VISUOSPATIAL/EXECUTIVE — POINTS

Copy cube [ ]

Draw CLOCK (Ten past eleven) (3 points) [ ] Contour [ ] Numbers [ ] Hands — /5

NAMING [ ] [ ] [ ] — /3

MEMORY Read list of words, subject must repeat them. Do 2 trials, even if 1st trial is successful. Do a recall after 5 minutes. — NO POINTS

	FACE	VELVET	CHURCH	DAISY	RED
1ST TRIAL					
2ND TRIAL					

ATTENTION Read list of digits (1 digit/ sec.). Subject has to repeat them in the forward order. [ ] 2 1 8 5 4 — /2

Subject has to repeat them in the backward order. [ ] 7 4 2

Read list of letters. The subject must tap with his hand at each letter A. No points if ≥ 2 errors [ ] F B A C M N A A J K L B A F A K D E A A A J A M O F A A B — /1

Serial 7 subtraction starting at 100. [ ] 93 [ ] 86 [ ] 79 [ ] 72 [ ] 65 — /3

4 or 5 correct subtractions: **3 pts**, 2 or 3 correct: **2 pts**, 1 correct: **1 pt**, 0 correct: **0**

LANGUAGE Repeat: I only know that John is the one to help today. [ ] — /2

The cat always hid under the couch when dogs were in the room. [ ]

Fluency: Name maximum number of words in one minute that begin with the letter F. [ ] _____ (N ≥ 11 words) — /1

ABSTRACTION Similarity between e.g. orange - banana = fruit [ ] train - bicycle [ ] watch - ruler — /2

DELAYED RECALL — /5

	(MIS)	Has to recall words WITH NO CUE	FACE	VELVET	CHURCH	DAISY	RED	Points for UNCUED recall only
Memory Index Score (MIS)	X3		[ ]	[ ]	[ ]	[ ]	[ ]	
	X2	Category cue						MIS = ____ /15
	X1	Multiple choice cue						

ORIENTATION [ ] Date [ ] Month [ ] Year [ ] Day [ ] Place [ ] City — /6

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MIS: /15 (Normal ≥ 26/30) Add 1 point if ≤ 12 yr edu

TOTAL — /30

Administered by: _____

Training and Certification are required to ensure accuracy

BEDSIDE COGNITIVE TESTING

The Mini-Mental State Examination (MMSE)

The MMSE is another test of cognition that can be performed in a few minutes at the bedside. Unlike the MoCA, the MMSE is copyright protected.

Interviewing Skills

GENERAL APPROACHES TO TYPES OF PATIENTS

- **Violent Patient:** Do not interview a potentially violent patient alone. Inform staff of your whereabouts. Know if there are accessible panic buttons.
- To assess violence or homicidality, one can simply ask, "Do you feel like you want to hurt someone or that you might hurt someone?" If the patient expresses imminent threats against specific friends, family, or others, the doctor must notify potential victims and/or protection agencies **(Tarasoff Rule).**

- **Delusional Patient:** Although you should not directly challenge a delusion or insist that it is untrue, you should not imply you believe it either; you should simply acknowledge that you understand that the patient believes the delusion is true.

- **Depressed Patient:** A depressed patient may be skeptical that they can be helped. It is important to offer reassurance that they can improve with appropriate therapy. Inquiring about suicidal thoughts is crucial; a feeling of hopelessness, substance use, and/or a history of prior suicide attempts reveal an risk for suicide. If the patient is actively planning or contemplating suicide, they should be hospitalized or otherwise protected.

Diagnosis and Classification

DIAGNOSIS AS PER DSM-5

- The American Psychiatric Association (APA) uses a criterion-based system for diagnoses. Criteria and codes for each diagnosis are outlined in the DSM-5.

Diagnostic Testing

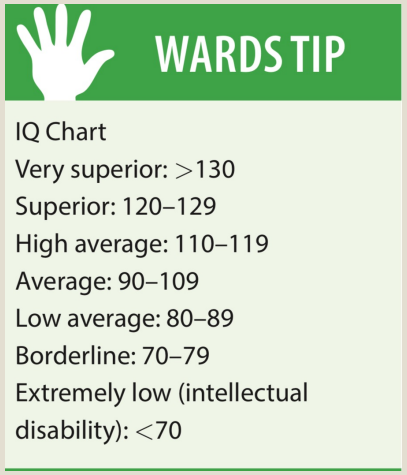
- INTELLIGENCE TESTS
- OBJECTIVE PERSONALITY ASSESSMENT TESTS
- PROJECTIVE !PERSONALITY" ASSESSMENT TESTS

INTELLIGENCE TESTS

- Aspects of intelligence include memory, logical reasoning, ability to assimilate factual knowledge, and understanding of abstract concepts.

Intelligence Quotient (IQ)

- IQ is a test of intelligence with a mean of 100 and a standard deviation of 15. !ese scores are adjusted for age.
- An IQ of 100 signifies that mental age equals chronological age and corresponds to the 50th percentile in intellectual ability for the general population.



Intelligence tests assess cognitive function by evaluating comprehension, fund of knowledge, math skills, vocabulary, picture assembly, and other verbal and performance skills.

Two common tests are:

Wechsler Adult Intelligence Scale (WAIS):

- Most common test for ages 16–90.
- Assesses overall intellectual functioning.
- Four index scores:
  - Verbal comprehension,
  - perceptual reasoning,
  - working memory,
  - processing speed.

Wechsler Intelligence Scale for Children (WISC):

- Tests intellectual ability in patients ages 6–16

OBJECTIVE PERSONALITY ASSESSMENT TESTS

These tests are questions with standardized-answer format that are objectively scored.

Minnesota Multiphasic Personality Inventory (MMPI-2):

- Tests personality for different pathologies and behavioral patterns.
- Most commonly used.
- The mean score for each scale is 50 and the standard deviation is 10.

PROJECTIVE (PERSONALITY) ASSESSMENT TESTS

Projective tests have no structured-response format. The tests often ask for interpretation of ambiguous stimuli.

Examples are:

Thematic Apperception Test (TAT)

- Test taker creates stories based on pictures of people in various situations.
- Used to evaluate motivations behind behaviors.

Rorschach Test

- Interpretation of inkblots.
- Used to identify thought disorders and defense mechanisms

THANKS