

# **Clinical interview: psychiatric history and mental status**

- **general introduction**
- **choosing a place and meeting the patient**
- **applying interviewing techniques**
- **taking a psychiatric history**
- **mental status examination**

# General introduction

- the purpose of a diagnostic interview is to gather information that will help the examiner make a diagnosis - the diagnosis guides treatment
- psychiatric diagnoses are based on descriptive phenomenology: signs, symptoms, and clinical course
- the psychiatric examination consists of the two arts: **a psychiatric history, and mental status examination**

# Choosing a place and meeting the patient

- choosing a quiet place
- new patient almost certainly will be anxious (being worried by his symptoms and apprehensive about what your assessment will be)
- shake hand and introduce yourself, use formal address (i.e. Mr., Ms.), invite patient to sit down
- be sure your patient understands the reason for your meeting (e.g. to evaluate the problems)
- your interviewing style: **helping your patient tell you what is wrong!**

# Applying interviewing techniques

- allow the interview to flow freely, let patient describe the events of his life in any order he chooses, encourage him to elaborate on thoughts and feelings
- provide structure for pts. who have trouble ordering their thoughts -specific questions
- phrase your question to invite the patient to talk (open vs. closed questions)
- avoid leading questions
- help patient to elaborate ( „Tell me more about it, please go on“)

# Applying interviewing techniques

- **reflect your patient's feeling back to him (correctly verbalise patient's feelings)**
- **paraphrase the patient's thought („You mean, you did not feel better?“)**
- **summarise what the patient has said**
- **additional tips : avoid jargon, use the patient's words, avoid asking why, identify thoughts versus feelings, avoid premature reassurance**

# **Taking a psychiatric history**

- 1. Identifying data: (name, age, ethnic, sex, occupation, number o children, place of residence)**
- 2. Referral source**
- 3. Chief complaint („What brings you to see me?“)**
- 4. History of the present problem:**
  - onset of problem**
  - duration and course**
  - psychiatric symptoms**
  - severity of problem**
  - possible precipitants**

# Taking a psychiatric history

## 5. Past psychiatric history:

- all previous episodes and symptoms
- prior treatments and response, hospitalisations

**The best predictor of future treatment response is past treatment response !**

# Taking a psychiatric history

## 6. Personal history:

### Infancy:

- birth history, developmental milestones

### Childhood:

- pre-school years, school, academic performance

### Adolescence:

- onset of puberty, early sexual experience
- peer relationship

### Adulthood

- education, military experiences, employment
- social life, sexual history, marriage, children



# **Taking a psychiatric history**

**7. Family history of mental illness**

**8. Medical history:**

- **current medical condition and treatment**
- **major past illnesses and treatments**
- **medical hospitalisations**
- **surgical history**

**9. Drug and alcohol history**

# **Mental status examination**

- 1. Appearance and behaviour (dress, facial expression, eye contact, motor activity)**
- 2. Speech (rate, clarity)**
- 3. Emotions**
  - subjective - patient's description**
  - objective -emotion communicated through facial expression, body posture and vocal tone**  
**(mood-a sustained emotion, affect - the way the patient shows feelings- variability, intensity, liability, appropriateness)**

# **Mental status examination**

## **4. Thought**

### **a) thought form:**

- **the way ideas are linked (logical, goal-directed, loose associations)**

### **b) thought content:**

- **delusions (false beliefs)**
- **thought insertion, thought withdrawal**
- **depersonalisation and derealisation (sense of unreality or strangeness)**
- **preoccupations, obsessions - unwanted idea that cannot be eliminated by reasoning**
- **phobia- obsessive, unrealistic fear**

# **Mental status examination**

**Examples of questions (concerning thought disorder):**

- **Do you think anyone wants to hurt you?**
- **Do you feel that others can hear your thoughts or read your mind?**

**Additional tips:**

- **When something does not appear to make sense, always ask for clarification!!**
- **Most important question: determining the presence of psychosis!**

# Mental status examination

## 5. Perception:

- misinterpreting sensory input -illusion
- perceiving sensory input in the absence of any actual external stimulus - hallucination

(„Do you ever hear voices or see things other people do not hear or see?“)

**Determine to what extent the patient is driven to actions based on a hallucination !**

# **Mental status examination**

## **6. Sensorial and intellectual functions:**

- **alertness (degree of wakefulness)**
- **orientation to person, place, time and situation**
- **concentration (to focus and a sustain attention)**
- **memory recent and remote, immediate recall (repeat 5 number forwards and backwards)**
- **calculation (simple arithmetic)**
- **fund of knowledge**
- **abstraction (proverbs, similarities)**
- **judgement and insight**

# Literature

- **Waldinger R.J.: Psychiatry for medical students, Washington, DC : American Psychaitric Press, 1997**
- **Kaplan HI, Sadock BJ, Grebb JA.: Kaplan and Sadock´s synopsis of psychiatry, Baltimore: Williams and Wilkins, 1997**

# **Diagnostic systems in psychiatry**

**2 diagnostic systems:**

- **american (APA) – DSM V**
- **european (WHO)**



# General psychopathology



Adapted from Raboch et al.

# Basic Terms in Psychiatry

- **Psychiatry** studies the causes of mental disorders, gives their description, predicts their future course and outcome, looks for prevention of their appearance and presents the best ways of their treatment
- **Psychopathology** describes symptoms of mental disorders
- **Special psychiatry** is devoted to individual mental diseases
- **General psychiatry** studies psychopathological phenomena, symptoms of abnormal states of mind:
  1. consciousness
  2. perception
  3. thinking
  4. memory
  5. mood (emotions)
  6. intelligence
  7. motor
  8. personality

# Disorders of Consciousness

- **Consciousness** is awareness of the self and the environment
- Disorders of consciousness:
  - qualitative
  - quantitative
    - short-term
    - long-term
- **Hypnosis** – artificially incited change of consciousness
- **Syncope** – short-term unconsciousness

# Disorders of Consciousness

- **Quantitative changes of consciousness** mean reduced vigility (alertness):
  - somnolence
  - sopor
  - coma
- **Qualitative changes of consciousness** mean disturbed perception, thinking, affectivity, memory and consequent motor disorders:
  - delirium (confusional state) – characterized by disorientation, distorted perception, enhanced suggestibility, misinterpretations and mood disorders
  - obnubilation (twilight state) – starts and ends abruptly, amnesia is complete; the patient is disordered, his acting is aimless, sometimes aggressive, hard to understood
    - stuporous
    - vigilambulant
    - delirious
    - Ganser sy

# Disturbances of Perception

- Perception is a process of becoming aware of what is presented through the sense organs
- Imagery means an experience within the mind, usually without the sense of reality that is part of reality
- **Pseudoillusions** – distorted perception of objects which may occur when the general level of sensory stimulation is reduced
- **Illusions** are psychopathological phenomena; they appear mainly in conditions of qualitative disturbances of consciousness (missing insight)
- **Hallucinations** are percepts without any obvious stimulus to the sense organs; the patient is unable to distinguish it from reality

# Disturbances of Perception

## **Hallucinations:**

- auditory (acousma)
- visual
- olfactory
- gustatory
- tactile (or deep somatic)
- extracampine, inadequate
- intrapsychic (belong rather to disturbances of thinking)
- hypnagogic and hypnopompic (hypnagogic)

**Pseudohallucinations** - patient can distinguish them from reality

# Disorders of Thinking

- Thinking
- Cognitive functions
- Disorders of thinking:
  - quantitative
  - qualitative

# Definition

**Thinking:** Goal-directed flow of ideas and associations initiated by a problem and leading toward a reality-oriented conclusion.

Thinking is a very complex and complicated psychic function.

The evaluations of thoughts is based on what the patient says



# Quantitative Disorders of Thinking

## **Quantitative (formal) disorders of thinking:**

- poverty of thought
- thought blocking
- flight of ideas
- perseveration
- loosening of associations
- word salad - incoherent thinking
- neologisms
- verbigeration

# **Quantitative disturbances:**

## **1. disturbances of speed of thinking**

### **a) slowed thoughts:**

- **slowing of the flow of associations , slowed and diminished verbal production (bradypsychism)**
- **blocking of thoughts - cessation of the flow of associations ( patient stops the verbal production without any recognisable impulse from surroundings)**

### **Occurrence:**

**depression, schizophrenia**

# **Quantitative disturbances:**

## **1. disturbances of speed of thinking**

### **b) flight of thoughts:**

- **excessive rapidity of thinking manifested as extreme rapidity in speech (= logorrhoea)**

**Occurrence :**

**mania**

# **Quantitative disturbances:**

## **2. disturbance of structure of thinking**

### **a) perseverative thinking:**

- **involuntary persistence of response to some question or topic, verbigeration - a meaningless repetition of specific word or phrase**

### **b) circumstantiality:**

- **indirect speech that is delayed in reaching the point, characterised by an overinclusion of details**

### **c) tangentiality:**

- **patient never gets from desired point to desired goal**

**Occurrence:**

**fatigue, organic mental disorders**

# **Quantitative disturbances:**

## **2. disturbance of structure of thinking**

### **d) illogical thinking:**

- **thinking containing erroneous conclusions or internal contradiction**
- **neologism: new word created by the patient often by combining syllables or other words**

### **e) incoherent thinking:**

- **thought that is not understandable**
- **word salade: incoherent mixture of words and phrases**

**Occurrence:**

**schizophrenia**

# Qualitative Disorders of Thinking

**Qualitative disorders of thought** (content thought disorders):

- **Delusions:**
  - a) belief firmly held on inadequate grounds,
  - b) not affected by rational arguments
  - c) not a conventional belief
- **Obsessions** (obsessive thought) are recurrent persistent thoughts, impulses or images entering the mind despite the person's effort to exclude them. Obsessive phenomena in acting (usual as senseless rituals – cleaning, counting, dressing) are called **compulsions**.

# Qualitative Disorders of Thinking

## Division of delusions:

- according to onset
  - a) primary (delusion mood, perception)
  - b) secondary (systematized)
  - c) shared (folie a deux)
- according to theme
  - a) paranoid (persecutory) - d. of reference, d. of jealousy, d. of control, d. concerning possession of thought
  - b) megalomaniac (grandiose, expansive) – d. of power, worth, noble origin, supernatural skills and strength, amorous d.
  - c) depressive (micromaniac, melancholic) – d. of guilt and worthlessness, nihilistic d., hypochondriacal d.
  - d) concerning the possession of thoughts
    - thought insertion
    - thought withdrawal
    - thought broadcasting

# **Qualitative disturbances: disturbances of content of thoughts**

## **a) preoccupation of thought:**

- **certain idea is in the centre of thinking, is coming back, usually associated with a strong affective tone**

## **b) obsession:**

- **pathological persistence of an irresistible thought or feeling that cannot be eliminated from consciousness by logical effort, associated with anxiety**

## **Occurrence:**

**obsessive-compulsive disorder, schizophrenia**

## **c) autistic (derealistic) thinking:**

- **preoccupation with inner, private world**



# **disturbances of content of thoughts**

## **d) overvalued idea:**

- **unreasonable, sustained false belief maintained less firmly than a delusion**

## **e) poverty of content:**

- **thought that gives little information because of vagueness, empty repetitions, or obscure phrases**

## **f) symbolic and magical thinking:**

- **real objects have other, symbolic meaning, in magical thinking words, situations, action have special power and meaning**

**Occurrence:**

**schizophrenia**

# **Delusions**

## **Definition:**

**Delusions are false beliefs based on incorrect inference about external reality, not consistent with patient's intelligence and cultural background that cannot be corrected by reasoning**

## **Characteristics:**

- **bizarre content**
- **not corrected by reasoning**
- **influence on behaviour**

# **Delusions - classification according to the content**

## **Melancholic delusions:**

- **delusion of self accusation (false interpretation of real past event resulting in feeling of guilt)**
- **hypochondriac delusion (false belief of having a fatal physical illness)**
- **nihilistic delusions (false feeling that self, others or the world is non-existent or ending)**
- **delusions of failure (false belief that one is unable to do anything useful)**
- **delusion of poverty (false belief that one lost all property)**

# **Delusions - classification according to the content**

## **Delusions of grandeur:**

- **delusion of importance (exaggerated conception of one's importance)**
- **delusion of power, extrapotence (exaggerated conception of one's abilities/possibilities)**
- **delusion of identity (false belief of being the offspring of member of an important family)**

# Delusions - classification according to the content

**Paranoid delusions:** are based on ideas of reference (false ideas that behaviour of others refers to a patient):

- delusion of persecution (false belief that one is being persecuted)
- delusion of infidelity (false belief that one's lover is unfaithful)
- erotomanic delusion (false belief, that someone is deeply in love with them)

# **Delusions - classification according to the content**

**Delusion of control (false feeling that one's will, thought or feelings are being controlled):**

- **thought withdrawal (false belief that one's thought are being removed from one's mind by other people of forces)**
- **thought insertion (false belief that thought are being implanted in one's mind by other people or force)**
- **thought broadcasting (false belief that one's thought can be heard by others)**
- **thought control (false belief that one's thoughts are being controlled by other people of forces)**

# Schizophrenia

- **most devastating illness**
- **characterized by a broad range of mental symptoms**
- **1% of the population**

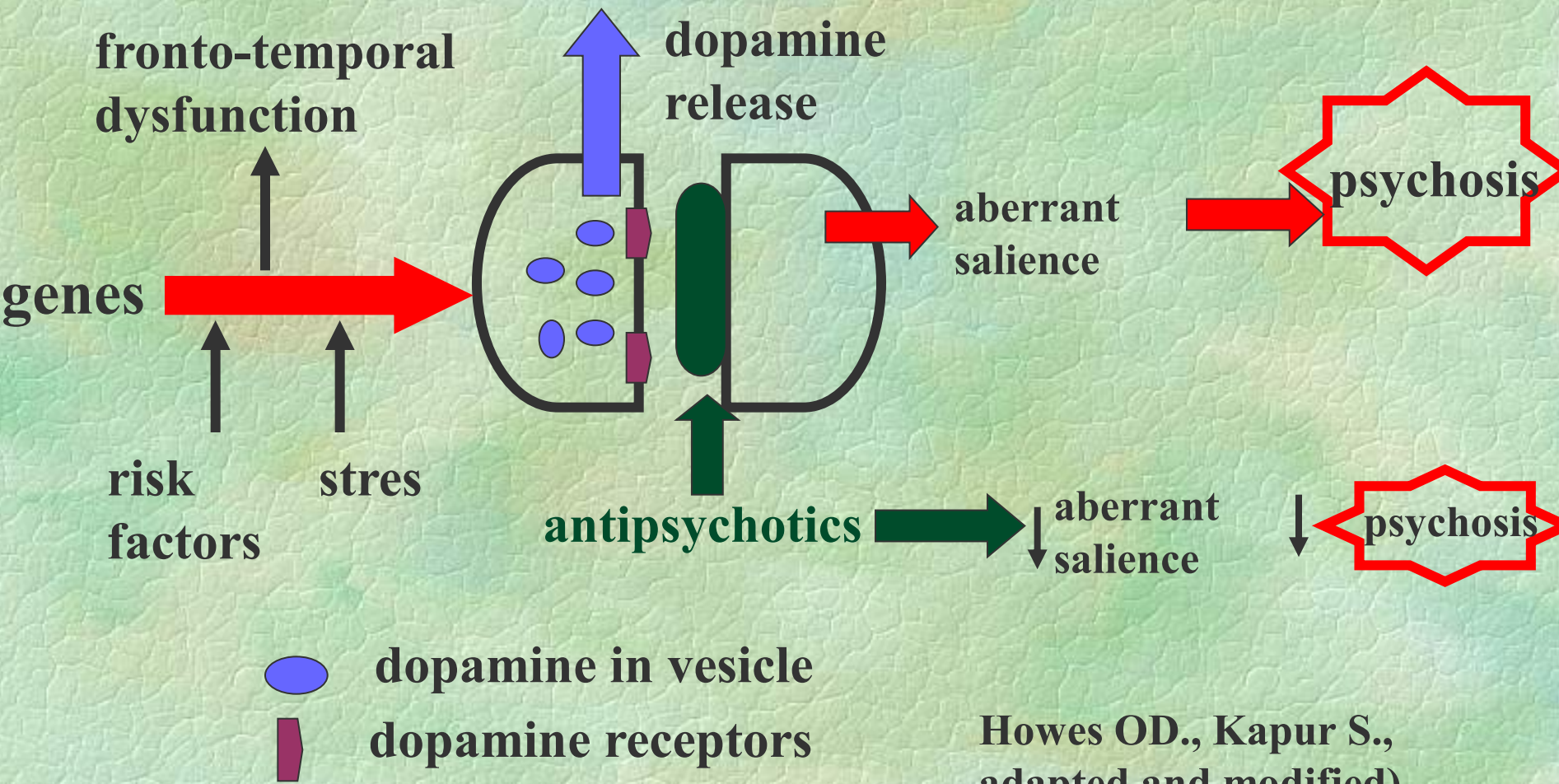
# Schizophrenia- symptoms

## **Thought disorder:**

- any disturbance of thinking that affects language, communication, or thought content
- the hallmark feature of schizophrenia
- manifestations range from simple blocking and mild circumstantiality to profound loosening of associations, incoherence, and delusions



# Schizophrenia results from interactions between a genetically mediated neurobiological vulnerability and nongenetic second hits of stressors



Howes OD., Kapur S., adapted and modified)

# **Etiology: dopamine hypothesis**

- **hyperdopaminergia**



- **subcortical hyperdopaminergia with prefrontal hypodopaminergia**



- **increased presynaptic striatal dopaminergic function**

# Schizophrenia – symptoms

## DSM V criteria

**A. 2 ( or more) of the the following, each present for a significant portion of time during a 1-month period:**

- **Delusion**
- **Hallucinations**
- **Disorganized speech (derailment, incoherence)**
- **Disorganized or catatonic behaviour**
- **Negative symptoms (affecti e flattening, alogia, avolition)**

**B social/occupational dysfunction)**

**C Durationsigns of disturbance persis for at least 6 months**

# Schizophrenia – symptoms

- positive

Vs

- Negative
- Other symptoms
  - affective symptoms
  - cognitive impairment

# Cognitive dysfunction

- a stable, trait-related aspect, being present in nonpsychotic relatives as well
- a key diagnostic component
- present in the majority of pts with schizophrenia
- signif. higher occurrence in pts than in healthy controls
- more robust compared to other psych. disorders
- average effect sizes for cognitive impairment are about twice as large as those obtained in structured MRI studies
- predicts outcome as evaluated longitudinally

# Schizophrenia – symptoms

## Thought disorders in schizophrenia

### a) autistic (derealistic) thinking:

- preoccupation with inner, private world

### b) overvalued idea:

- unreasonable, sustained false belief maintained less firmly than a delusion

### c) poverty of content:

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### d) symbolic and magical thinking:

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# **Schizophrenia – symptoms**

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# Criteria for remission of schizophrenia: (PANSS based) PANSS = Positive and Negative Syndrome Scale

## Severity only

- Score three (mild) or less on all eight of the following PANSS items
  - P1 delusions
  - P2 conceptual disorganisation
  - P3 hallucinatory behaviour
  - G5 mannerisms and posturing
  - G9 unusual thought content
  - N1 blunted affect
  - N4 passive/apathetic social withdrawal
  - N6 lack of spontaneity and flow of conversation

## Severity x time

- As above for at least 6 months

# Disorders of Memory

- **Sensory stores** - retains sensory information for 0.5 sec.
- **Short - term memory (working memory)** - for verbal and visual information, retained for 15-20 sec., low capacity
- **Long-term memory** – wide capacity and more permanent storage
  - declarative (explicit) memory – episodic (for events) or semantic (for language and knowledge)
  - procedural memory – for motor arts
  - priming – unconscious memory
  - conditioning – classic or emotional

# Disorders of Memory

## **Disorders of memory:**

- Amnesia – inability to recall past events
- Jamais vu, déjà vu
- Confabulation, amnesic disorientation, Korsakov's syndrome
- Pseudologia phantastica
  
- Hypomnesia
- Hypermnesia

# Disorders of Attention

- Concentration
- Capacity
- Tenacity
- Irritability
- Vigility
  
- Hypoprosesia (global, selective)
- Hyperprosесia
- Paraprosesia

# Disorders of Mood (Emotions)

Normal affect – brief and strong emotional response

Normal mood – subjective and for a longer time lasting disposition to appear affects adequate to a surrounding situation and matters discussed

Higher emotions:

- intellectual
- aesthetic
- ethic
- social

# Disorders of Mood (Emotions)

Pathological affect – very strong, abrupt affect with a short change of consciousness on its peak

Pathological mood – two poles:

- manic
- depressive

Phobia – persistent irrational fear and wish to avoid a specific situation, object, activity:

- agoraphobia
- claustrophobia
- social phobias
- hipsophobia
- aichmophobia
- keraunophobia

Depersonalization – change of self-awareness, the person feels unreal, unable to feel emotion

# Disorders of Mood (Emotions)

- Pathological mood:
  - origin – based on pathological grounds, no psychological cause
  - duration – unusually long-lasting
  - intensity – unusually strong, large changes in intensity
  - impossibility to be changed by psychological means
  
- Pathological features of mood:
  - euphoria
  - expansive
  - exaltation
  - explosive
  - mania
  - hypomania
  - depression
  - apathy (anhedonia)
  - blunted, flattened affect
  - emotional lability
  - helpless



# **Mood disorders ( affective disorders )**

**Mood disorders - the critical pathology in those disorders is one of mood**

# Diagnosis: major depressive disorder

Minim. 5 symptoms, change from functioning:

- **depressed mood**
- **diminished interest or pleasure**
- significant weight loss, or decrease or appetite
- insomnia ( or hypersomnia)
- psychomotor agitation or retardation
- fatigue or loss of energy
- feelings of worthlessness or guilt
- diminished ability to think or concentrate, indecisiveness
- recurrent thought of death

# **Diagnosis: Bipolar I, manic episode**

**At least 1 week of abnormally and persistently elevated, expansive or irritable mood, impairment in occupational functioning or social activities (not due to abuse or medical condition), min. 3 of the following symptoms:**

- **grandiosity**
- **decreased need for sleep,**
- **more talkativeness**
- **flight of ideas**
- **distractibility**
- **increase of goal directed activity**
- **excessive involvement in pleasurable activities**

# **Diagnosis : dysthymic disorder**

**Dysthymic disorder: a chronic disorder, with the depressed mood that lasts most of the day on most days**

**Symptoms:**

- **depressed mood for more days than not, for at least 2 y.**

**2 or more further symptoms:**

- **poor appetite or overeating**
- **insomnia or hypersomnia**
- **low energy or fatigue**
- **low self esteem**
- **poor concentration or difficulty making decisions**
- **feelings of hopelessness**

# **Diagnosis : Cyclothymic disorder**

- **a mild form of bipolar II disorder, characterised by episodes of hypomania and episodes of mild depression**
- **for at least 2 years, the presence of numerous periods with hypomanic symptoms and numerous period with depressive symptoms that do not meet criteria for a major depressive episode**

# Intelligence Disorders

- Intelligence:

- abstract
- practical
- social

- Intelligence quotient (IQ):

$$\text{IQ} = (\text{mental age} : \text{calendar age}) \times 100$$

- Disorders of intellect:

- mental retardation
- dementia

# Motor Disorders

**Motor disorders** occur frequently in mental disorders of all kinds, especially in catatonic schizophrenia.

- quantitative:

- hypoagility
- hyperagility
- agitated behaviour

- qualitative:

- mannerisms
- stereotypies
- posturing
- waxy flexibility
- echopraxia
- negativism
- short-circuit behaviour
- automatism
- agitation
- tics
- compulsions

# Disorders of Volition

## **Disorders of volition:**

- hypobulia
- abulia
- hyperbulia



# Disorders of Personality

- **Personality** means a complex of persistent mental and physical traits of a person
  
- Disturbances of personality:
  - transformation of personality
  - appersonalization
  - multiple personality (alteration of personality)
  - specific personality disorder
  - deprived personality

# Literature

- **Kaplan HI, Sadock BJ, Grebb JA.:**  
**Kaplan and Sadock's comprehensive textbook of psychiatry, ninth edition**
- **Editors: Sadock BJ, Sadock VA, Ruiz P.**
- **Lippincott Williams and Wilkins, 2009**

# Literature:

- **Waldinger RJ.: Psychiatry for medical students, Washington, DC : American Psychaitric Press, 1997**
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