# Psychiatric Assessment

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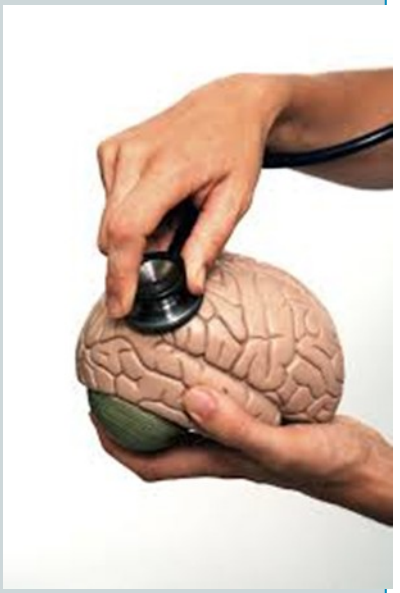
# Psychiatric Assessment

**Primary aims**

- to make a differential diagnosis
- to formulate a treatment plan



**Main method**

- an interview with the patient

- how the patient thinks and feels

# Three sources of information

- Subjective feelings
  - think, feel, perseive…
  - **what** the patient says
- Behaviour and nonverbal communication
  - express themselves, speak, gesticulation…
  - **how** the patient says it
- Objective information
  - family, friends…

# Settings and techniques I

- Place
  - choose a quiet, private place
  - free from outside distractions
- Duration
  - it takes approximately one hour
- Language
  - try to use natural, commonly understood language
  - avoid jargon and technical terms

# Settings and techniques II

- Interviewing style
  - provide a pleasant atmosphere
  - help the patient to tell you what is wrong
- Empathy
  - very important quality in psychiatric interviewing
  - putting oneself in another´s place and experiencing his/her state of mind, so as to understand how he/she feels , thinks and behaves

# Settings and techniques III

- Helpful interventions
  - Repetition
  - Restatement
  - Summarization
  - Clarification
  - Asking for example
  - Support
- NOT
  - moralize, judge, advice

# Settings and techniques IV

- **Open-ended questions -** as often as possible - especially at the beginning

  X

- **Closed-ended questions** - targeted questions for psychopatology

- Good questions often begin: *who, what, when, how much, how many*
- Less useful questions: *why*
  - they tend to provoke defensiveness

# Phases of the Interview I

- **1. Opening**
- **2. Middle**
- **3. Closing**

- **1. Opening phase**
  - the interviewer and patient are introduced (shake hand, introduce yourself, invite patient to sit down)
  - purposes and procedures of the interview are set

- <u>Typical opening questions:</u>
  - *"What brings you to see me/to the hospital today?"*
  - *"How did you come to be in the hospital right now?"*
  - *"What sort of trouble have you been having?"*
  - *"Tell me about the problem that bring you here."*

# Phases of the Interview II

- **2. Middle phase**
  - the main part of the interview, we gain all the information we need to determine a diagnosis

- **3. Closing phase**
  - summarize the most important problem
  - interviewer shares his/her conclusion with the patient and makes treatment recommendations
  - allow the patient to correct or add to the salient facts as understood by the interviewer

# Step by step

1. Identifying data

2. Chief complaint

3. Psychiatric history

4. Mental status examination

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# 1. Identifying data

- Name
- Age/date of birth
- Birth certificate number
- Marital status
- Occupation
- Place of residence

# Step by step

1. Identifying data

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# 2. Chief Complaint

- „What brings you to see me today?“
  - use quotation marks
  - use the language of the patient

# Step by step

1. Identifying data

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# 3.Psychiatric History

- I. PAST MEDICAL HISTORY
- II. FAMILY HISTORY
- III. PAST PSYCHIATRIC HISTORY
- IV. PERSONAL HISTORY
- V. HISTORY OF THE PRESENT ILLNESS

# 3.Psychiatric History

- **I. PAST MEDICAL HISTORY**

- patient's general health status
- current medical illnesses and treatment
- major past ilnessess and treatment
- medical hospitalizations
- surgical history

# 3.Psychiatric History

- **II. FAMILY HISTORY**

- family history of mental illness
- dates and causes of death and other important chronic illnesses of family members

- **III. PAST PSYCHIATRIC HISTORY**

- all previous episodes and symptoms
- previous treatment and response
- previous hospitalization

# 3.Psychiatric History

- **IV. PERSONAL HISTORY**
  - Infancy
- birth history, developmental milestones
  - Childhood
- pre-school years, school, academic performance
  - Adolescence
- onset of puberty, early sexual experiance, peer relationship
  - Adulthood
- education, employement, social life, sexual history, marriage, children

# 3.Psychiatric History

- **V. HISTORY OF THE PRESENT ILLNESS**

- onset of the problem (the approximate time since the patient was last at his/her baseline level of functioning)
- duration and course
- psychiatric symptoms
- severity of problem
- possible precipitants

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# 4.Mental status examination (MSE)

- the task is to explore and describe all areas of psyche
- explicit description (no jargon)

# 4.Mental status examination (MSE)

- ***I. Appearance (observed)***
- ***II. Behavior (observed)***
- ***III. Attitude (observed)***
- ***IV. Level of Consciousness (observed)***
- ***V. Orientation (inquired)***
- ***VI. Speech and Language (observed)***
- ***VII. Mood (inquired)***
- ***VIII. Affect (observed)***
- ***IX. Thought Process/Form (observed/inquired)***
- ***X. Thought Content (observed/inquired)***
- ***XII. Perception (observed/inquired)***
- ***XII. Suicidality and Homicidality (inquired)***
- ***XIII. Insight and Judgment (observed/inquired)***
- ***XIV. Attention Span (observed/inquired)***
- ***XV. Memory (observed/inquired)***
- ***XVI. Intellectual Functioning (observed/inquired)***

# 4.Mental status examination (MSE)

- ***I. Appearance***
  - e.g. gait, posture, clothes, grooming…
- ***II. Behavior***
  - e.g. mannerisms, gestures, psychomotor activity, eye contact…
- ***III. Attitude***
  - e.g. cooperative, hostile, open, suspicious, apathetic, easily distracted, defensive…
- ***IV. Level of Consciousness***
  - e.g. igilant, alert, drowsy, lethargic, comatose, confused…

# 4.Mental status examination (MSE)

- ***V. Orientation***
  - to person -place -time -situation
- ***VI. Speech and Language***
  - quantity -rate -volume  -fluency and rhythm
- ***VII. Mood***
  - a sustained state of inner feeling
- ***VIII. Affect***
  - an observed expression of inner feeling

# 4.Mental status examination (MSE)

- ***IX. Thought Process/Form***
  - the way ideas are linked
- ***X. Thought Content***
  - f.e. delusions, thought insertion/withdrawal, obsessions…
- ***XI. Perception***
  - illusions and hallucinations
- ***XII. Suicidality and Homicidality***
- ***XIII. Insight and Judgment***
  - knows something is wrong, that he/she is ill, that illness is psychiatric

# 4.Mental status examination (MSE)

- ***XIV. Attention Span***
  - attend –concentration -distractibility
- ***XV. Memory***
  - recent -remote -immediate memory
- ***XVI. Intellectual Functioning***
  - information –vocabulary -abstraction

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# Specific situations

- Suicidal patient
- Agressive patient

# Suicidal patient

- common cause of emergent psychiatric consultations
- the psychiatrist needs to ask about suicidality directly
- Don´t be afraid to ask!

- <u>Example of questions:</u>
  - “Do you ever feel that life isn’t worth living? Or that you would just as soon be dead?”
  - “Have you ever thought of doing away with yourself? If so, how?”
  - “What would happen after you were dead?”

# Suicidal patient

- **Suicidal course**

- **Suicidal Ideation** – How frequent are the thoughts of killing themselves? How long have they been present? Are they changing in intensity or frequency?
- **Suicidal Plan** – Do they have a specific plan to end their life? Is it realistic? Is it lethal? Are they likely to be rescued in the attempt?
- **Suicidal Intent** – Do they want to die? Do they feel it is inevitable that they will die?
- **Preparation and Rehearsal for Suicide** – Have they obtained lethal means? Have they practiced the suicide attempt?
- **Suicide Attempts** – Have they ever tried to kill themselves in the past? Do they have family or friends who have committed suicide?

# Suicidal patient

- **Static risk factors for suicide**
  - Male Sex
  - Age – young adults,  older people
  - Race – higher in White and Native Americans than in Black and Hispanic Americans
  - Family history of suicide
  - Prior Suicide Attempts
  - Being Single
- **Dynamic risk factors for suicide**
  - Untreated mental illness
  - Emotional Turmoil
  - Expressed suicidality
  - Access to weapons and other lethal means

# Suicidal patient

- **Warning signs**
  - hopelessness, rage, anger, acting recklessly, feeling trapped, increasing alcohol or drug use, withdrawal from friends, anxiety, agitation, altered sleep, dramatic changes in mood, and seeing no reason for living, direct threats to harm themselves, searching for, means to kill themselves, and writing or talking about death and dying.

# Suicidal patient

- **High–risk person**
  - Male, white, age greater than 65 years
  - Widowed or divorced
  - Living alone; no children under the age of 18 in the household
  - Presence of stressful life events
  - Access to firearms

# Suicidal patient

- **Protective factors**
  - Effective clinical care for mental, physical, and substance abuse disorders
  - Easy access to a variety of clinical interventions and support for help seeking
  - Family and community support (connectedness)
  - Support from ongoing medical and mental health care relationships
  - Skills in problem solving, conflict resolution, and nonviolent ways of handling disputes
  - Cultural and religious beliefs that discourage suicide and support instincts for self-preservation

# Aggressive patient

- Don´t stay alone with your patient in the room without chance to call for help
- Always sit close to the door with the possibility to escape
- Remove dangerous objects from examination room/from patien´t access
- Don´t turn your back to the patient
- Keep the safe distance (more then 1 meter)
- End up the interview if needed
- In case of danger – try to get a time, move to safer place, call for help, inform the Police if needed

# References


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- **Thank you very much for your attention**