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 live 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 heat 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 (hypnexagogic)

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 a 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 erroneaous 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: incohorent mixture of words and phrases**

Occurence:

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) megalomanic (grandiose, expansive) – d. of power, worth, noble origin, supernatural skills and strength, amorous d.
  c) depressive (micromanic, 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 (dereistic) 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

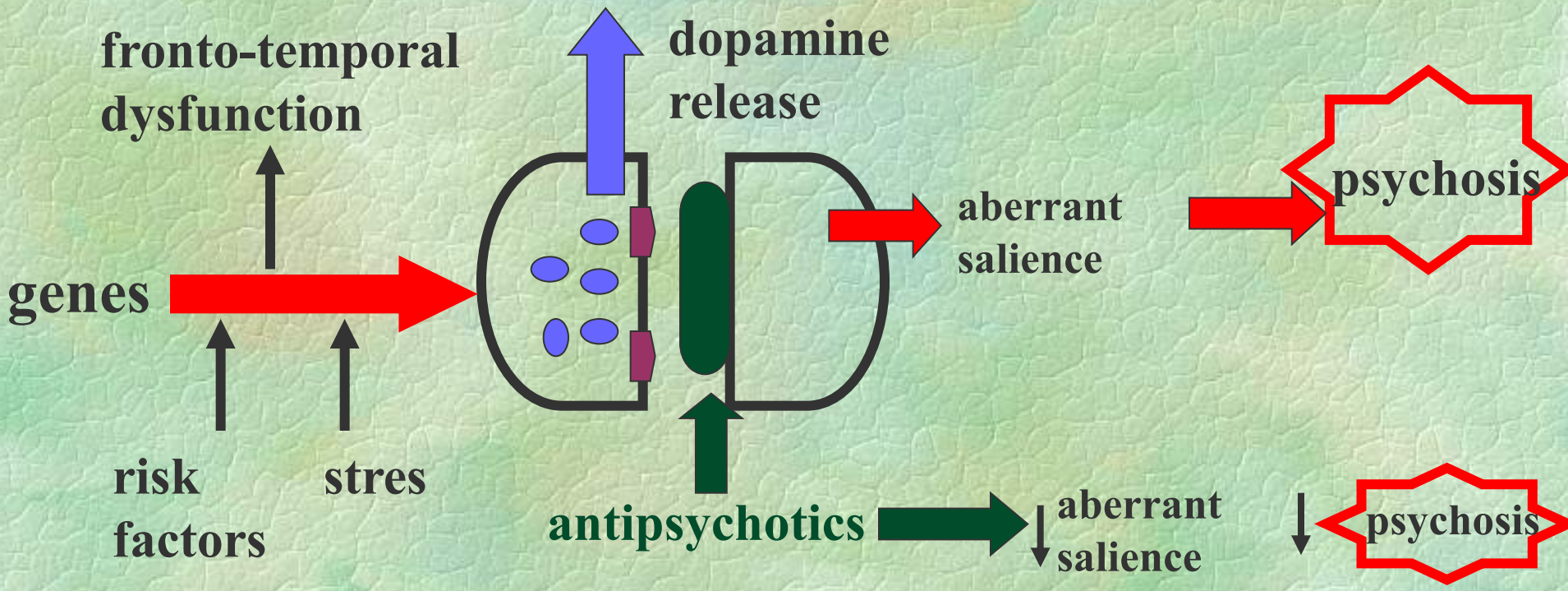
- most devastating illness
- characterized by a broad range of mental symptoms
- 1% of the population

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

Howes OD. et Kapur S., 2009

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

Keefe RS et al., 2005, Saykin AJ et al., 1991

Schizophrenia – symptoms

Thought disorders in schizophrenia

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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, déja vu
- Confabulation, amnesic disorientation, Korsakov's syndrome
- Pseudologia phantastica

- Hypomnesia
- Hypermnesia

Disorders of Attention

- Concentration
- Capacity
- Tenacity
- Irritability
- Vigility

- Hypoprosexia (global, selective)
- Hyperprosexia
- Paraprosexia

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):

  IQ = (mental age : calendar age) x 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

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