

Psychiatric assessment

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General overview

- <https://www.youtube.com/watch?v=7ac2IND4YIs>

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

- choose a quiet place
- new patients will almost certainly be anxious (being worried by their symptoms and about what the assessment will be like)
- 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/her life in any order he/she chooses, encourage him/her 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 (mis)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

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

Taking a psychiatric history

- ◎ 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

◎ Personal history:

- > Infancy:
 - birth history, developmental milestones
- > Childhood:
 - pre-school years, school, academic performance
- > Adolescence:
 - onset of puberty, early sexual experience,
 - peer relationships
- > Adulthood
 - education, military experiences, employment
 - social life, sexual history, marriage, children

Taking a psychiatric history

- Family history of mental illness
- Medical history:
 - > current medical condition and treatment
 - > major past illnesses and treatments
 - > medical hospitalisations
 - > surgical history
- Drug and alcohol history

Mental status examination

1. **Appearance and behaviour** (dress, facial expression, eye contact, motor activity)
2. **Speech** (rate, clarity)
3. **Emotions (affect)**
 1. subjective - patient's description
 2. 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 speed

b. thought form:

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

c. thought content:

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

Thought

- 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!!

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 !

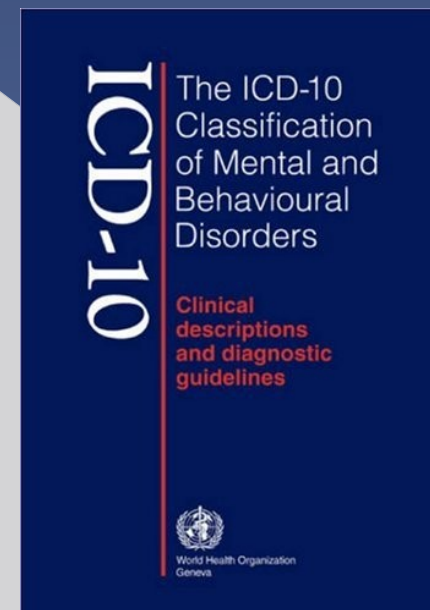
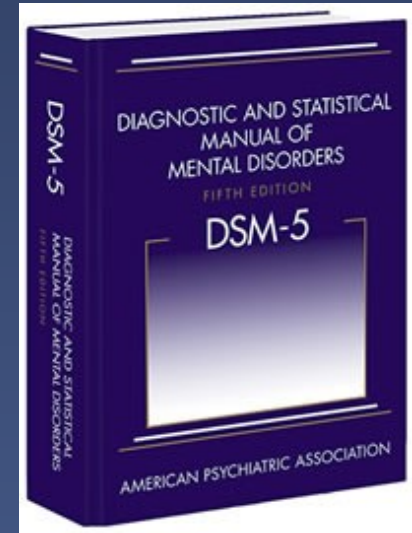
Mental status examination

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

Diagnostic systems in psychiatry

- 2 diagnostic systems:
 - American (American Psychiatric Association, APA) – DSM 5
 - European and international (WHO) – ICD-10



General psychopathology

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:
 - > consciousness
 - > perception
 - > thinking
 - > mood (emotions)
 - > memory
 - > intelligence
 - > motor
 - > personality

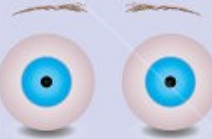


Disorders of Consciousness

- ◎ **Consciousness** is awareness of the self and the environment
- ◎ Disorders of consciousness:
 - > qualitative
 - > quantitative
 - short-term
 - long-term

Disorders of Consciousness

◉ Quantitative changes of consciousness mean reduced vigility (alertness):

- > somnolence
- > sopor
- > coma

Behaviour	Response
 Eye Opening Response	<ol style="list-style-type: none">1. No response2. To pain3. To speech4. Spontaneously
 Verbal Response	<ol style="list-style-type: none">1. No response2. Incomprehensible sounds3. Inappropriate words4. Confused5. Oriented to time, person and place
 Motor Response	<ol style="list-style-type: none">1. No response2. Abnormal extension3. Abnormal flexion4. Flex to withdraw from pain5. Moves to localised pain6. Obeys command

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Disorders of Consciousness

- ◉ **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

Disorders of Orientation

- ◎ Orientation by oneself (autopsychic)
 - > Knows his/her name, address, date of birth
- ◎ Orientation by circumstances (allopsychic)
 - > Time
 - > Place
 - > Situation

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

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

Disorders of Mood (Emotions)

- Pathological mood:
 - > origin – based on pathological grounds, usually no psychological cause
 - > duration – unusually long-lasting
 - > intensity – unusually strong, large changes in intensity
 - > impossibility to be changed by psychological or voluntary means

- Pathological moods:
 - > euphoria
 - > expansive
 - > exaltation
 - > explosive
 - > maniac (hypomaniac)
 - > depressive
 - > anxious
 - > apathy (anhedonia)
 - > blunted, flattened affect
 - > emotional lability
 - > helpless

<https://www.coursera.org/learn/international-psychiatry/lecture/X6lZW/the-affect-in-the-mental-state-examination>

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 normal
- **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

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

Disorders of Thinking

- ◉ **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 mental function
- ◉ The evaluation of thoughts is based on what the patient says (via speech)

Disorders of Thinking

- ◉ Disorders of thinking:
 - > Thought process (formal disorders)
 - Speed
 - Structure
 - > Thought content

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
- > <https://www.coursera.org/learn/international-psychiatry/lecture/BzKL8/the-thought-process-in-the-mental-state-examination>

Disorders of Thinking

- ◉ **Qualitative disorders** of thought (content thought disorders):
 - > **Delusions:**
 - belief of (usually) bizarre content
 - formed by logical thinking process but based on a pathological assumption or input
 - not corrected by rational arguments
 - not a conventional belief (not shared)
 - influence the behaviour

Disorders of Thinking

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

- **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**.

◎ <https://www.coursera.org/learn/international-psychiatry/lecture/kIFvK/thought-content-and-the-delusion>

Delusions - division

- according to onset
 - > a) primary (delusional mood, perception)
 - > b) secondary (systematized)
 - > c) shared (folie à deux)
- according to the topic
 - 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

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 or bizarre somatic condition)
- ◉ **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 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/origin (false belief of being the offspring of member of an important family)
- Messiah delusion

Paranoid delusions

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

Delusion of control

- false feeling that one's will, thought, movements or feelings are being controlled by someone else
- May include:
 - > Thought withdrawal
 - > Thought insertion
 - > Thought broadcasting
 - > Thought control

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)
 - semantic (for language and knowledge)
 - > procedural memory – for motor patterns

Disorders of Memory

- ◎ Quantitative:
 - > Hypermnesia
 - > Hypomnesia
 - > Amnesia
 - anterograde
 - retrograde
 - Usually with amnesic desorientation and confabulations

Disorders of Memory

- Qualitative (paramnesia)
 - > Distorted memory tracks

Disorders of Attention

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

Disorders of Volition

- ⦿ hypobulia
- ⦿ abulia
- ⦿ hyperbulia

Presentations

- ◎ Psychosis:
<https://www.youtube.com/watch?v=ZB28gfSmz1Y&t=35s>
- ◎ Depression:
<https://www.youtube.com/watch?v=4YhpWZCdiZc>
- ◎ Mania:
<https://www.youtube.com/watch?v=zA-fqvC02oM&list=PLFZTljPAn-Kx257X3b9ET8qZfVOcC8V5o&index=7&t=0s>