

# 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

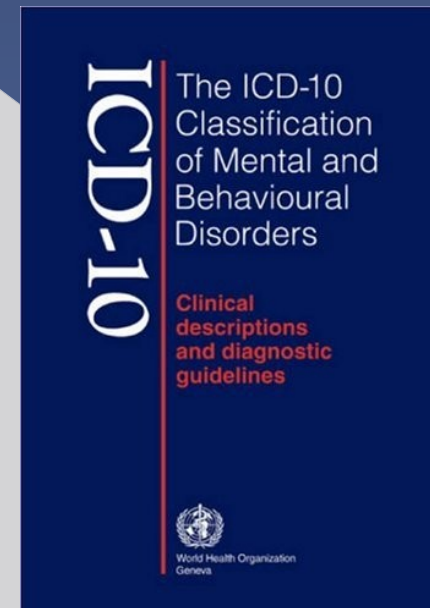
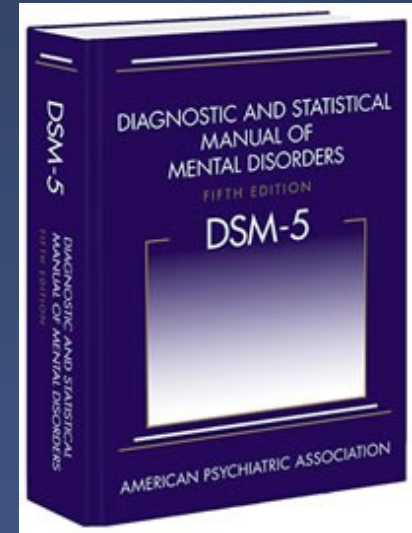
## 6. Sensorial and intellectual functions:

- > 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   |
|---|--|
| <br>Eye Opening Response | <ol style="list-style-type: none"><li>1. No response</li><li>2. To pain</li><li>3. To speech</li><li>4. Spontaneously</li></ol>  |
| <br>Verbal Response     | <ol style="list-style-type: none"><li>1. No response</li><li>2. Incomprehensible sounds</li><li>3. Inappropriate words</li><li>4. Confused</li><li>5. Oriented to time, person and place</li></ol>                         |
| <br>Motor Response     | <ol style="list-style-type: none"><li>1. No response</li><li>2. Abnormal extension</li><li>3. Abnormal flexion</li><li>4. Flex to withdraw from pain</li><li>5. Moves to localised pain</li><li>6. Obeys command</li></ol> |

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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>