

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

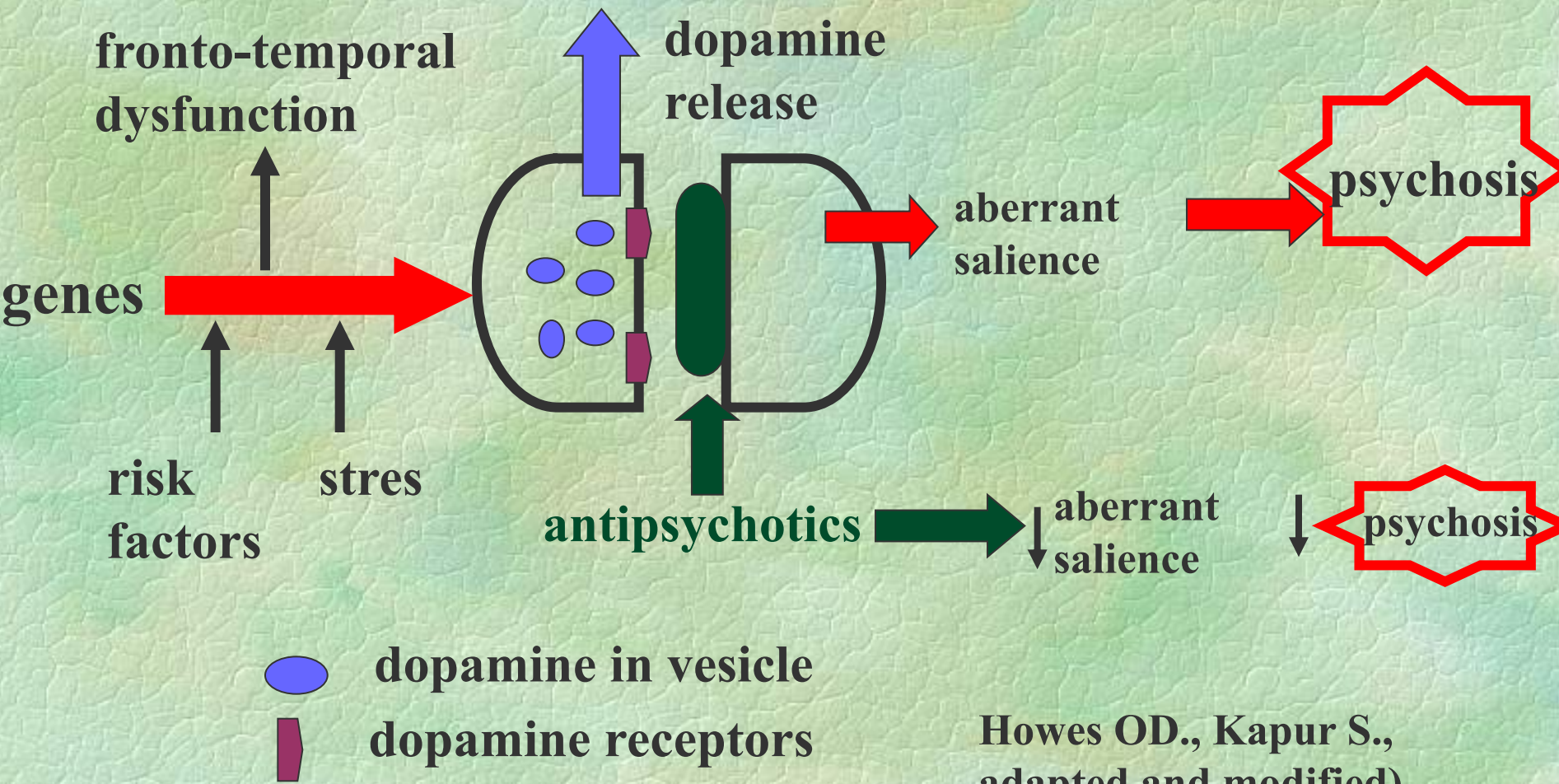
- **most devastating illness**
- **characterized by a broad range of mental symptoms**
- **1% of the population**

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

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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:

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