

Psychiatric Examination

Last updated: April 24, 2019

PSYCHIATRIC INTERVIEW.....	1
HISTORY OF PRESENT ILLNESS.....	2
PERSONAL HISTORY.....	2
PHYSICAL EXAMINATION.....	2
LABORATORY STUDIES.....	2
PSYCHOLOGICAL TESTING (S. PSYCHOMETRIC EVALUATION).....	2
PEDIATRIC ASPECTS.....	3

Psychiatric examination differs from routine medical examination in that it includes **mental status examination** rather than **physical examination** (although physical examination may be included).

Screen for **general medical conditions / substance abuse** almost all patients who have cognitive or behavioral changes! - medical conditions can cause symptoms that mimic almost every psychiatric diagnosis! - clinicians should evaluate psychiatric patients medically as well as psychiatrically!

e.g. mood disorders caused by thyroid conditions, personality changes sometimes seen in Wilson's disease, psychotic symptoms seen in some patients with epilepsy

- physical disorder as cause of mental symptoms is most likely indicated by **confusion & inattention**.

To determine psychiatric illness, following questions must be considered:

- (1) Do signs and symptoms **fit psychiatric diagnosis**?
e.g. when patients say they are sad or depressed, do their symptoms meet diagnostic criteria for diagnosis of depression?
- (2) Is there **family history** of similar symptoms?
– many psychiatric illnesses tend to have genetic or familial basis.
- (3) Is **longitudinal pattern** of symptoms consistent with natural history of psychiatric disorder?
– emotional symptoms associated with specific situations are classified as reactions to situation; they do not usually become psychiatric disorders.
- (4) Are symptoms **incapacitating**?
- (5) Do **delusions & hallucinations** exist?
– delusions and hallucinations in absence of other medical causes always indicate major psychiatric illness.
– illusory phenomena can occur with *sleep deprivation* or with certain *intoxications* or *fever*. However, their occurrence in patient with clear state of consciousness points to presence of major psychiatric illness.

- if findings do not fit into any defined psychiatric syndrome, physician should not make psychiatric diagnosis but should observe and re-evaluate patient - in many cases, symptoms resolve.
- for general medical physicians, **one in four** of patients they see have active, diagnosable psychiatric disease! (**only** \approx 1/2 of diagnosable psychiatric disorders in general medical ambulatory settings are recognized by physicians).

PSYCHIATRIC INTERVIEW

about MENTAL STATUS EXAMINATION → see p. D10 >>

about interview with patient in EMERGENCY → see p. Psy49 >>, p. Exam1 >>

Primary method of obtaining data is **face-to-face INTERVIEW**.

- **sensitivity & special skills** are required (many patients have embarrassment about disclosing emotional problems).
- **confidentiality** is important in all physician-patient interactions (do not discuss your patients in hallways or elevators!); **exceptions to rule of confidentiality** - need for safety (e.g. child abuse, threats to harm others).
- first, determine whether patient can provide history (i.e. whether patient readily and coherently responds to initial questions; if not, information is sought from family and caregivers).
- **collateral sources** (record review, interviews of persons close to patients) may provide important additional information.
N.B. always obtain patient's permission to question family members!
- sit at **eye level** with patient.
- **verbal communication** - during first few minutes of interview, physician should allow patient to talk about his symptoms.
- **nonverbal communication** (facial expression, posture) is equally important - note how story is told (i.e. tone of voice, feelings expressed).
- interruptions should be minimized - **sufficient time should be allowed for interview completion** (traditionally, interview is 50-60 min long, but 20 min may be enough).
- lead interview with use of both open-ended and direct questions:
Starting interview with discussion of patient's strengths and interests, rather than problems, often is helpful.
 - **OPEN-ENDED questions** allow patient to use his own words (e.g. "Tell me about your home life", "Tell me about your hospital stay").
 - **DIRECT questions** are used to elicit specific information (e.g. "Have you ever consulted mental health professional before?", "Are you thinking about killing yourself?").
- clearly communicate that you are listening:
 - **attentive silence** - *nodding* and *leaning forward* demonstrate attention; establish *eye contact*.
 - **facilitation** - encouraging comments (e.g. "Tell me more about it") helps patient focus while relating his history.
 - **summarization** of portions of patient's story - lets patient know that she is listening and allows patient to correct any misunderstanding (e.g. "So you have been increasingly sad for 3 weeks, during which time you have lost 7 pounds and have been waking up at 4:00 a.m.?).
 - **clarification** - similar to summary statements but also includes connections that patient may not recognize (e.g. "Your difficulty sleeping and your crying spells began in mid-September. Was this after your youngest child left for college?").
- **sudden alterations in behavior**, especially behavior with automatisms, suggest **seizure disorder** (seizures of frontal lobe origin may be extremely bizarre)!

Interviewer can establish rapport by **allowing patient to tell her own story** as much as possible; examiner should obtain relevant information with following questions:

1. What **symptoms / problems** led patient to seek help?
 2. Why is patient **seeking help now**?
 3. Why are these symptoms problem **at this particular time**?
 4. What are patient's normal **coping mechanisms** in times of **stress**?
 5. What is patient's **level of functioning** in general?
 6. How did patient cope with similar stresses **in past**?
 7. How is patient **attempting to resolve** problem? (if there is evidence of depression / anxiety, suicide risk should be assessed)
 8. Tactfully ask about behavior while **driving**; and any tendencies to **antisocial conduct**.
 9. What are patient's **attitudes regarding psychiatric treatments** (incl. drugs and psychotherapy) - information can be incorporated into treatment plan.
- **family members, friends, employers, coworkers** may be able to answer many of these questions if patient will not / cannot answer them accurately.

HISTORY OF PRESENT ILLNESS

1. Onset, duration, change of symptoms **over time**.
2. **Stressful events** (esp. losses - death of loved one, job loss, financial problems).
3. **Patient perception of any change in himself + perception of change in patient** by *another individual* (e.g. spouse, friend, work supervisor).
4. **Previous episodes & treatment** (incl. medication, hospitalization, other therapy and responses to treatment - both positive and negative).
5. **Somatic manifestations** (e.g. of mood, anxiety disorders).
6. Previous episodes of **self-destructive or assaultive behavior**.
7. **Legal issues** with respect to current illness (e.g. lawsuit, arrest, incarceration), **problems in school** (e.g. truancy, suspension, expulsion).
8. **Secondary gain** - any benefit that patient derives from current problem (e.g. monetary compensation; relief from responsibilities at home / school / work).

PERSONAL HISTORY

- information about **premorbid state** (background on which to view patient's current state).

1. **Developmental milestones:**
 - 1) **early development** (incl. details about mother's **pregnancy** and **delivery**).
 - 2) patient's **temperament** as child.
 - 3) important **family events** (e.g. death, separation, divorce).
 - 4) patient's **early experiences and relationships** - **school** [academic performance, delinquency], **friends**, **family** stability, **neglect / abuse**, early **sexual** experiences.
 - 5) **cultural** and **religious** influences.
2. **Social history:**
 - 1) **breadth** of patient's **social life** (e.g. whether he is loner, how difficult it is for him to establish friendships).
 - 2) any **changes in personality** noted by patient or by his family or friends.
 - 3) **marital status** or involvement in intimate relationship, as well as current level of **sexual functioning**.
 - 4) **educational status**.
 - 5) **employment history** (number of jobs held, reasons jobs were terminated, alcoholism or antisocial behavior at work).
 - 6) **military service history** (highest rank attained, disciplinary problems, combat experience).
3. **Family history:**
 - 1) whether any family members have undergone **psychiatric hospitalization**, attempted **suicide**, problems with **alcohol / psychotropic medication**.
 - 2) **genetic risk factors** for mental disorders.
 - 3) **family attitudes** toward mental illness.
4. **Previous psychiatric history:**
 - 1) episodes of any **other psychiatric illness** chronologically.
 - 2) any **previous treatments** in chronological order.
5. **Substance use and abuse** (be nonjudgmental, but ask specific questions):
Complete drug history is essential!
 - 1) screening questions about **alcohol and drug problems** (incl. whether family or friends have ever objected to patient's drinking or drug use and whether patient has ever felt that he has had problem with alcohol or drugs, either legal or illegal).
 - 2) use of **tobacco**.
 - 3) any **negative consequences** of substance use (tolerance, withdrawal, effect on present illness).

PHYSICAL EXAMINATION

- conducted if there is concern that undiagnosed medical / neurologic illness is contributing to or causing psychiatric symptoms.

1. **General appearance**
2. **Vital signs** (e.g. fever → perform lumbar puncture).
3. **Neurologic status** (esp. **frontal lobe signs** ["frontal release" reflexes, smell abnormalities, Foster Kennedy syndrome], visual field deficits, pupils, oculomotorics)
 - **stereotypic movements** (such as clapping, tapping, rubbing) may suggest **autism, mental retardation, schizophrenia**.
 - **deep tendon reflexes** may be accentuated during stress or anxiety.
 - obviously **factitious gait** may cast doubt on organicity of unexplained mood, emotion, or thought abnormality.
4. **Skin** - **scars** from self-injury, **tattoos**.

LABORATORY STUDIES

1. Screening for any **underlying medical / neurologic condition** that might be causing psychiatric symptoms (e.g. syphilis, HIV, SLE, thyroid dysfunction, hepatic encephalopathy, heavy metal poisoning, porphyria, epilepsy, sleep disorders)
 - there are some who believe that all **psychotic patients** should have at least one **brain imaging** study (MRI is more sensitive CT*).
 - *in general, imaging is done to look for masses / infarcts - usually large or multiple - CT is adequate and much less costly than MRI.
 - neuroimaging usefulness is questionable in "routine" disorders of mood, emotion, and thought.
 - **EEG** in **psychosis** should be normal vs. **metabolic disorders** can cause disorganization and generalized slowing;
 - rarely, disorders of emotion / mood / thought secondary to "subclinical seizures" or complex partial status epilepticus may be diagnosed only with EEG.
2. Monitoring **blood levels** of psychotropic **medications** (lithium, tricyclic antidepressants).
3. **Baseline of biologic indicators** as part of diagnosis and treatment process (e.g. ECG before giving tricyclic antidepressants).

PSYCHOLOGICAL TESTING (s. PSYCHOMETRIC EVALUATION)

- standardized objective measure of certain patient characteristics (behavioral, cognitive, and emotional functioning, personality), i.e. **SAMPLE OF BEHAVIOR** is **elicited, observed, recorded, scored, and interpreted**.
- complementary extension of psychiatric examination.
- conducted by trained **clinical psychologist**; administration and scoring of tests may be performed by **trained technician (psychometrist)**.
- performed for **specific indications** (i.e. not routinely):
 - 1) **not clear psychiatric diagnosis**
 - 2) patient with **brain injury** (e.g. to assist in treatment and rehabilitation planning).
 - 3) **vague symptoms** that are difficult to substantiate with standard psychiatric, neurologic, or medical examinations – to discriminate organic and functional impairment.
 - 4) to determine **baseline level** of functioning.
 - 5) to assess patients involved in **litigation**.
 - 6) questions about patient's **behavioral functioning** (e.g. impulse control, motivation, social maturity), **cognitive ability** (e.g. intellectual functioning, academic achievement, neurobehavioral impairment), **vocational issues** (e.g. career decisions, vocational rehabilitation), or **emotional and personality factors** (e.g. psychological conflicts and dynamics, suicide potential, reality testing).
- based on three important **principles**:
 1. **Standardization** - uniform, replicable procedure and normative database (representative of population for whom test will be used).
 2. **Reliability** - stability and accuracy of measurements:
 - 1) over time (**test-retest reliability**)
 - 2) across different versions of same measure (**alternate-forms reliability**)
 - 3) between scorers (**interscorer reliability**)
 - 4) among test items (**internal consistency reliability**)
 3. **Validity** (most important parameter to establish psychiatric diagnosis!*) - degree to which test measures what it is intended to measure.

*test can be well standardized and highly reliable, but without demonstrated validity, results may be misleading or meaningless

 - 1) **criterion-based (empirical) validity** - correlating scores on test in question with scores on another measure or criterion that accurately represents variable that test measures:
 - (a) **predictive validity** - correlation of measure with some criterion that is measured in future [e.g. correlating Medical College Admissions Test (MCAT) scores with performance in medical school].
 - (b) **concurrent validity** - association of test performance with performance of existing criterion [e.g. correlating results from new test to diagnose schizophrenia with those of known criterion, such as Schedule of Affective Disorders and Schizophrenia].
 - 2) **content validity** - **experts** determine that test content and scores correspond with variables to be measured.

t.y. **nieko nenutuokiantis apie testą ekspertas atlieka testą ir nustato kam jis skirtas.**
 - 3) **face validity** - similar to content validity, but is determined by test **user** rather than by experts.

t.y. high face validity - **ligonis atlikdamas testą lengvai nuspėja kam testas skirtas.**
 - 4) **construct validity** addresses various meanings and possible interpretations of test scores in relation to their underlying theoretical constructs. Evaluation of construct validity is complex process that may include determining how closely measurement of test variable converges, or correlates, with theoretically similar variables or how clearly measure can be discriminated from dissimilar variables.
- **objective vs. projective tests**:

Objective tests - highly standardized; clearly identifiable correct answers exist (true-false and multiple-choice tests are usually considered objective).

Projective tests - less structured and allow greater freedom for expression of individual ideas; based on **projective hypothesis** (individual who is given little structure and ambiguous stimuli will impose internal structure on interpretation of stimuli - will reveal [project] unconscious issues, conflicts, and aspects of personality and cognitive style).

1. **Neuropsychological & Intelligence tests** - assessment of cognitively mediated abilities. see p. D12 >>, p. D1 >>
2. **Personality tests** - assessment of personality adjustment and disorder, thought process and content, and personality style.
 - 1) **Minnesota Multiphasic Personality Inventory (MMPI)** - 550 yes-or-no questions.
 - results are given as **scores in 10 scales**: **hypochondriasis, paranoia, masculinity-femininity, psychopathy, depression, hysteria, psychasthenia, schizophrenia, hypomania, and social introversion**.
 - although test is **objective**, **trained psychologist** should interpret results.
 - 2) **Rorschach (inkblot) test** - 10 standard ambiguous inkblots are shown to patient in predetermined order.
 - many formats for administering and scoring Rorschach test, but most practitioners use objective method developed by John Exner and known as **Comprehensive System** - highly standardized, acceptable reliability and validity.
 - interviewer explores patient's responses.
 - test is **projective** (i.e. major projective test of personality assessment) - shows patient's **thinking** and **association patterns**.
 - 3) **thematic apperception test (TAT)** - also projective test - 30 pictures, not all of which are shown; psychologist chooses specific picture, depending on psychological area to be examined (e.g. one picture shows seated young woman looking up at older man - patient is asked to create story about picture).
 - test is **projective** - indirectly reveals patient's **fantasies, fears, and conflicts**.
 - reliability and validity are questionable, but test is widely used.
 - 4) **sentence completion test** - series of incomplete sentences that patient is asked to complete (e.g. "I am afraid . . . ", "I feel guilty . . . ", "My mother is . . . ").
 - test elicits patient's **associations**.
 - psychologist notes themes and tone of responses as well as any subject areas that patient avoids.
 - 5) **draw-a-person test** (originally used only with children, but it can also be used with adults) - patient is asked to draw picture of person; then patient is asked to draw person of sex opposite from person in first drawing.
 - test is **projective** - assumes that drawing represents to some degree patient's **view of himself**.
 - reliability and validity are questionable.

PEDIATRIC ASPECTS

- **physician must be advocate for child**, rather than for parents (but psychiatrist must deal respectfully and attempt to develop working relationship with parents).
 - parents should be seen frequently, especially at beginning of treatment.
- **PREADOLESCENTS** should be seen **alone** (**after parents** have been seen).
 - attempt to communicate by talking (if this is difficult, small assortment of toys, can help child communicate through play).

- **ADOLESCENTS** should be seen **alone** (their emerging and developmentally appropriate autonomy should be supported by seeing them *before parents* are seen).
 - avoid use of unnatural slang to bridge "generation gap".

Following should be observed during patient interview:

1. Child's reaction to **separation from parents**.
2. Child's behavior **toward interviewer** (e.g. anxious, very open, shy).
3. Child's perception of **people in general** (e.g. trustworthy or dangerous, reliable or neglectful, kind or hostile).
4. Choice of **verbal** versus **play** communication.
5. Clarity of child's **thought processes**.
6. Child's **level of development** (i.e. social, language, motor, psychosexual, cognitive, moral) and its appropriateness to child's age.
7. Ability of child to identify different **affective states** and to discharge these states in age-appropriate manner.
8. Ability of child to tolerate **frustration** and to **control impulses**.
in most cases, this may be observed through naturalistic circumstances such as setting limit on inappropriate behavior, declining inappropriate request, announcing end of session, or requiring child's assistance in cleaning up toys.
9. Child's perception of **himself** (e.g. competent or ineffectual, master or victim) and relative strength of his self esteem.
10. Child's reaction to **rejoining parents** after interview.

Gathering information from CHILD can be facilitated by requesting that child:

1. Make three **wishes** and elaborate on each wish.
2. Make **drawings** and elaborate on each drawing (drawings of people and families are especially helpful).
3. Describe **family**.
4. Describe important **nonfamily** members.
5. Describe favorite **television shows, movies, and musicians**, noting with whom child identifies.
6. Describe **problem** that initiated therapy and how family told her of appointment.
7. Describe **hopes and wishes** for future.

Interviewing PARENTS / CAREGIVERS:

1. Chronology of child's activities during **typical day**.
2. Parents are asked to provide examples of **events that precede and follow** specific behavior.
3. Parents are asked for their **interpretation** of typical age-related behaviors, **expectations** for child, level of **parenting interest, support** (e.g. social, emotional, financial) for fulfilling their parenting role, and **relationship with rest of their family**.
*some "problems" represent unrealistic parental expectations!
well-meaning parental reactions to problem may worsen it (e.g. overprotecting fearful, clinging child or giving in to manipulative child).*

BIBLIOGRAPHY for ch. "Psychiatry" → follow this [LINK >>](#)