The Psychiatric Interview

Fundamentals of Interviewing

Skills Required for an effective and comprehensive psychiatric interview:

- Openness
- Respect for the patient and family
- Appropriate use of therapeutic communication
- Ability to establish rapport
- Subjective and Objective data collection – using all senses
- Critical Thinking

The Psychiatric Interview is a focused, goal-directed, interactional process between the PMHNP and the patient and/or family.

Primary Goals of the Psychiatric Interview

- To gather intentional specific data
- To identify the health needs of the patient
- To plan for care
- To evaluate outcomes of care
- To evaluate ongoing health needs of the patient

An effective relationship with the patient will assist the PMHNP in this important process. To develop an effective relationship the PMHNP strives to

- ✓ Learn about the patient's motivation and interests for care
- ✓ Have an open and respectful engagement utilizing a non-judgmental approach
- ✓ Explore the patient's current emotional status
- ✓ Validate assumptions about the emotional status of the patient
- ✓ Display empathy
- ✓ Instill hope that the patient's concern can be addressed
- ✓ Develop a sense of partnership with the patient and family

Components of the Psychiatric Interview

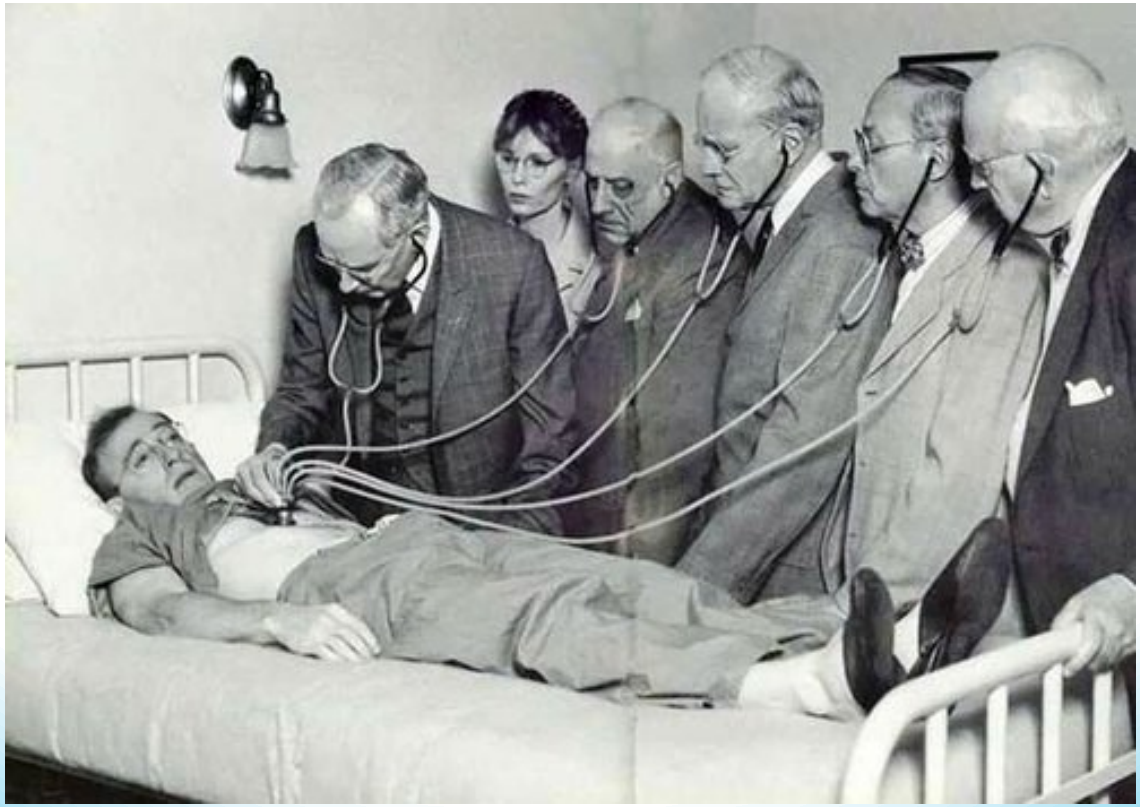
1 **History:**

- Biographical/demographic data
- Chief Complaint
- History of Present Illness (HPI)
- Past Psychiatric History
- Substance Use, Abuse, & Addictions
- Past Medical History
- Family History
- Developmental and Social History
- Functional Assessment

Psychiatric Interview

2 **Physical Exam:**

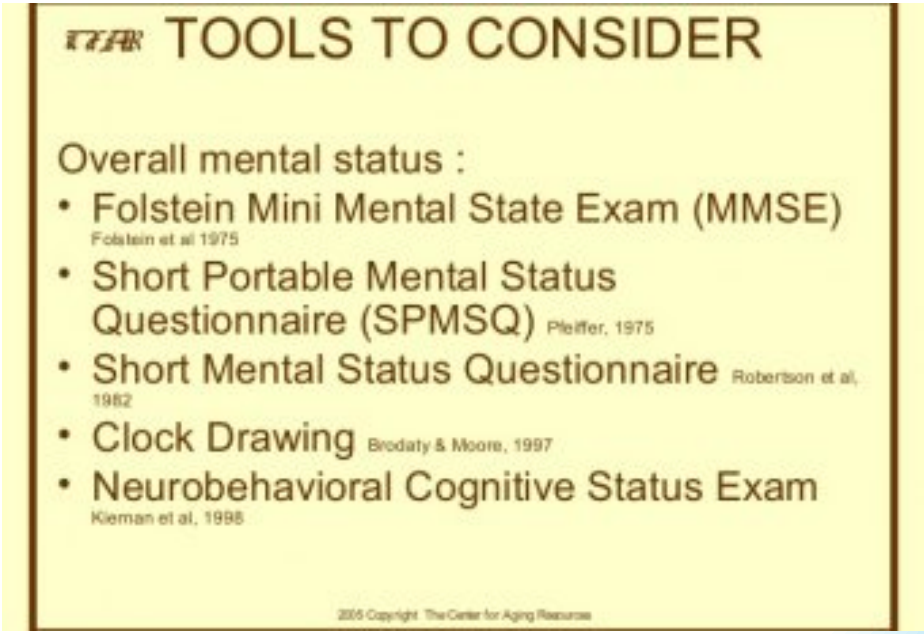
- Physical and Neurological Exam
- Review of Systems
- Vital Signs, laboratory and diagnostic results



Psychiatric Interview

3 **Mental Status Exam:**

- Appearance
- Behavior
- Motor Activity
- Speech
- Mood
- Affect
- Thought content
- Thought process
- Cognition:
  - Alertness
  - Orientation
  - Attention/Concentration
  - Memory
  - Abstract Reasoning
  - Insight
  - Judgment



Biographical/Demographic Information

Identifying data gathered about the patient allows the clinician to not only identify who the patient is, but also allows the PMHNP to locate her within the context of social and cultural norms.

Biographical/Demographic Information includes:

- ❑Name
- ❑Age, Date of Birth
- ❑Gender
- ❑Marital Status or Significant Other Relationship
- ❑Race or Ethnicity
- ❑Occupation
- ❑Referral Source
- ❑Insurance Status
- ❑Language Preference
- ❑Religious Preference

Clarify where the information has come from and how reliable the data are!

Chief Complaint

The chief complaint is the information that will set the stage for the psychiatric interview that follows.

The chief complaint is the patient's presenting problem.

The chief complaint should is the patient's explanation, regardless of how bizarre or irrelevant it is and should be recorded verbatim and placed in quotation marks.

Example:

"My wife made me come here. There is nothing wrong with me."

History of Present Illness

One of the most important parts of the psychiatric interview and the most helpful part in making a diagnosis.

Provides a chronological and comprehensive picture of the events leading up to the current moment in the patient's life as well as allowing the clinician insight into why the patient is seeking help now.

Information to ascertain for the HPI includes:

- **Onset of symptoms – including a list of symptomology. Is this a new complaint? How long has it been a problem? Is there a time of day when symptoms are worsened?**
- **What makes the symptoms better?**
- **What makes the symptoms worse?**
- **Is the problem affecting other areas of the patient's life such as work or relationships?**
- **How impactful is the problem on a day to day basis?**

Include any other changes that have occurred during this same time period in the patient's interests, interpersonal relationships, behaviors, personal habits, and physical health.

HISTORY OF PRESENT ILLNESS

- When the patient was well the last time should be noted.
- The time of onset
- When the symptoms are first noticed by the patient or by the relatives.
- The symptoms of the illness from the earliest time at which a change was noticed until the present time should be narrated chronolo-gically, in a coherent manner.

A Psychiatric Review of Systems May Assist in Ruling In or Ruling Out Diagnoses

In conjunction with the history of the present illness- helps rule in or out psychiatric diagnoses with pertinent positives and negatives. This may help to identify whether there are comorbid disorders or disorders that are actually more bothersome to the patient but are not initially identified for a variety of reasons.

Table 5.1-2
Psychiatric Review of Systems

1. Mood
   - A. Depression: Sadness, tearfulness, sleep, appetite, energy, concentration, sexual function, guilt, psychomotor agitation or slowing, interest. A common pneumonic used to remember the symptoms of major depression is SIGECAPS (**S**leep, **I**nterest, **G**uilt, **E**nergy, **C**oncentration, **A**ppetite, **P**sychomotor agitation or slowing, **S**uicidality).
   - B. Mania: Impulsivity, grandiosity, recklessness, excessive energy, decreased need for sleep, increased spending beyond means, talkativeness, racing thoughts, hypersexuality.
   - C. Mixed/Other: Irritability, liability.
2. Anxiety
   - A. Generalized anxiety symptoms: Where, when, who, how long, how frequent.
   - B. Panic disorder symptoms: How long until peak, somatic symptoms including racing heart, sweating, shortness of breath, trouble swallowing, sense of doom, fear of recurrence, agoraphobia.
   - C. Obsessive-compulsive symptoms: Checking, cleaning, organizing, rituals, hang-ups, obsessive thinking, counting, rational vs. irrational beliefs.
   - D. Posttraumatic stress disorder: Nightmares, flashbacks, startle response, avoidance.
   - E. Social anxiety symptoms.
   - F. Simple phobias, for example, heights, planes, spiders, etc.
3. Psychosis
   - A. Hallucinations: Auditory, visual, olfactory, tactile.
   - B. Paranoia.
   - C. Delusions: TV, radio, thought broadcasting, mind control, referential thinking.
   - D. Patient's perception: Spiritual or cultural context of symptoms, reality testing.
4. Other
   - A. Attention-deficit/hyperactivity disorder symptoms.
   - B. Eating disorder symptoms: Binging, purging, excessive exercising.

(Sadock, Sadock, and Ruiz, 2015)

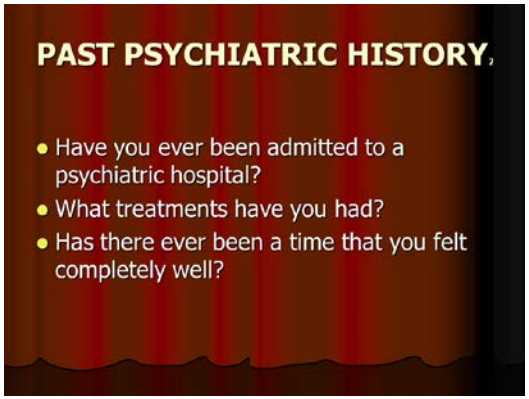
Past Psychiatric History

Specific psychiatric disorders have a natural course of development, characteristic risk factors, prodromal signs, ages of onset, and prognoses.

The Past Psychiatric History allows the PMHNP to determine the course and severity of the disorder.

The Past Psychiatric History Includes:

- **Past Diagnosed Mental Disorders**
- **Remissions or Exacerbations including Hospitalizations and Outpatient Treatment – Including Psychotherapy**
- **Responses to Treatment**
- **Past Psychotropic Treatment**
- **Responses to Psychotropic Intervention**
- **Past Suicidal/Homicidal Ideations or Attempts**



Past Psychiatric History - continued

A helpful mnemonic for Treatment History is Go CHaMP:

- **General Questions**
- **Who is your current Caregiver?**
- **Have you ever been psychiatrically Hospitalized?**
- **Have you taken Medications for these symptoms?**
- **Have you had Psychotherapy?**

Special consideration should be given to establishing a lethality history that is important in the assessment of current risk. Past suicidal ideation, intent, plan, and attempts should be reviewed including the nature of attempts, perceived lethality of the attempts, save potential, suicide notes, giving away things, or other death preparations. Violence and homicidality history will include any violent actions or intent. *Specific questions about domestic violence, legal complications, and outcome of the victim* may be helpful in defining this history more clearly. History of non-suicidal self-injurious behavior should also be covered including any history of cutting, burning, banging head, and biting oneself.

Average Age of Onset of Major Psychiatric Disorders (Carlat, 2012)

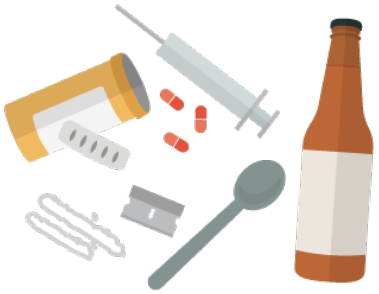
TABLE 14.1. Median age at onset of major psychiatric disorders

Disorder	*Age (yr)*
Schizophrenia	21 (men), 27 (women)
Major depression	25
Bipolar disorder	19
Panic disorder	24
Obsessive-compulsive disorder	23
Drug abuse/dependence	18
Alcohol abuse/dependence	21

Adapted from Burke, J. D., and Regier, D. A. (1994). Epidemiology of mental disorders. In R. E. Hales, S. C. Yudofsky, and J. A. Talbott (Eds.), *American Psychiatric Press Textbook of Psychiatry*. Washington, DC: American Psychiatric Press, 19.

Substance Use, Abuse, Addictions

Current substance abuse or dependence can have a significant impact on psychiatric symptoms and treatment course.



History of use should include:

- Substance used – alcohol, medications (prescribed or not prescribed to the patient)
- Routes of use – oral, snorting, or intravenous
- Frequency and amount
- Tolerance - need for increasing amounts of use)
- Withdrawal symptoms to determine abuse versus dependence
- Impact of use on social, occupational, or school domains
- Legal consequences

Substances and Addictions Continued

Any periods of sobriety should be noted including length of time and setting such as in jail, legally mandated, and so forth. A history of treatment episodes should be explored, including inpatient detoxification or rehabilitation, outpatient treatment, group therapy, or other settings including self-help groups, Alcoholics Anonymous (AA) or Narcotics Anonymous (NA), halfway houses, or group homes.

Other important substances and addictions that should be covered in this section include tobacco and caffeine use, gambling, eating behaviors, and Internet use.

Gambling history should include casino visits, horse racing, lottery and scratch cards, and sports betting.

Addictive type eating may include binge eating disorder.

Screening Questionnaire for Alcohol Abuse or Dependence

CAGE

CAGE Questionnaire to Assess for Substance Abuse

CAGE Questionnaire for Detecting Alcoholism

Question	Yes	No
C: Have you ever felt you should **C**ut down on your drinking?	1	0
A: Have people **A**nnoyed you by criticizing your drinking?	1	0
G: Have you ever felt **G**uilty about your drinking?	1	0
E: Have you ever had a drink first thing in the morning (**E**ye opener)?	1	0

A total score of 0 or 1 suggests low risk of problem drinking
A total score of 2 or 3 indicates high suspicion for alcoholism
A total score of 4 is virtually diagnostic for alcoholism

RAPS 4

Rapid Alcohol Problems Screen

RAPS-4 (4 Questions)

- During the last year have you had a feeling or guilt or remorse after drinking?

  REMORSE

- During the last year has a friend or family member ever told you about things you did while you were drinking that you could not remember?

  AMNESIA

- During the last year have you failed to do what was normally normally expected of you because of drinking?

  PERFORM

- Do you sometimes take a drink in the morning when you first get up?

  STARTER

Past Medical History

The PMH should reflect a chronological history of medical problems, treatment, and responses to treatment. It includes an account of major medical illnesses and conditions as well as treatments, both PAST and PRESENT.

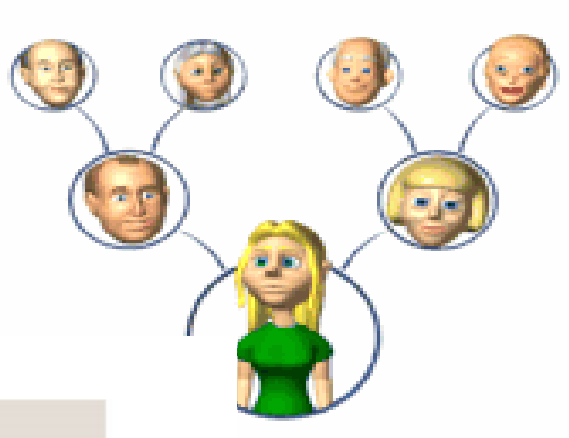
The PMH is important as it can assist in distinguishing between organic and psychiatric disorders. The PMH is also important in determining potential causes of psychiatric symptoms as well as comorbid or confounding factors that could influence or dictate treatment options.

"Medical illnesses can precipitate a psychiatric disorder (e.g., anxiety disorder in an individual recently diagnosed with cancer), mimic a psychiatric disorder (hyperthyroidism resembling an anxiety disorder), be precipitated by a psychiatric disorder or its treatment (metabolic syndrome in a patient on a second-generation antipsychotic medication), or influence the choice of treatment of a psychiatric disorder (renal disorder and the use of lithium carbonate) (Sadock, Sadock, and Ruiz, 2015).

Include in the Past Medical History:

- ✓ Major medical illnesses and treatment
- ✓ Past surgeries
- ✓ Medical hospitalizations
- ✓ Neurological issues: seizures, head injury, pain disorder
- ✓ Prenatal or birthing problems
- ✓ Reproductive and menstrual history
- ✓ Current medications: Psychiatric: how long used, compliance, effect, side effects, non-psychiatric, over-the-counter medications, sleep aids, herbal, and alternative medicines
- ✓ Allergies to medications: medication, nature and extent of reaction, treatment of allergic response
- ✓ Current Primary Care Physician and other medical specialists – include last visit and findings
- ✓ Preventative care status: immunizations, age, gender, and ethnicity related recommendations

Family History



Careful review of family history is an essential part of the psychiatric assessment because many psychiatric illnesses are familial and a significant number of those have a genetic predisposition, if not cause.

Name	Life prevalence	Heritability	Essential characteristics	Notable feature
Alzheimer's disease	0.132	0.58	Dementia, defining neuropathology	Of the top ten causes of death in the United States, Alzheimer's disease alone has increasing mortality
Attention-deficit hyperactivity disorder (ADHD)	0.053	0.75	Persistent inattention, hyperactivity, impulsivity	Costs estimated at ~$US100 × 10^9 per year
Alcohol dependence (ALC)	0.178	0.57	Persistent ethanol use despite tolerance, withdrawal, dysfunction	Most expensive psychiatric disorder (total costs exceed US$225 × 10^9 per year)
Anorexia nervosa	0.006	0.56	Dangerously low weight from self-starvation	Notably high standardized mortality ratio
Autism spectrum disorder (ASD)	0.001	0.80	Markedly abnormal social interaction and communication beginning before age 3	Huge range of function, from people requiring complete daily care to exceptional occupational achievement
Bipolar disorder (BIP)	0.007	0.75	Manic-depressive illness, episodes of mania, usually with major depressive disorder	As a group, nearly as disabling as schizophrenia
Major depressive disorder (MDD)	0.130	0.37	Unipolar depression, marked and persistent dysphoria with physical and cognitive symptoms	Ranks number one in the burden of disease in the world
Nicotine dependence (NIC)	0.240	0.67	Persistent nicotine use with physical dependence (usually cigarettes)	Major preventable risk factor for many diseases
Schizophrenia (SCZ)	0.004	0.81	Long-standing delusions and hallucinations	Life expectancy decreased by 12–15 years

*Most of these definitions are made more restrictive by requiring persistence over time (for example, the criteria for SCZ require ≥6 months of symptoms), substantial impairment and presence across multiple different contexts. See Supplementary information S1 (table) for more detail. Additional sources are REFS 1,2,181–183).

Family History Data Collection

Family to include in this history is the family of origin and the nuclear family.

Family history data to include:

- **Age**
- **If deceased, year, age, and cause of death**
- **Psychiatric diagnoses and medications – response to medications**
- **Psychiatric hospitalizations**
- **Substance use disorders**
- **Lethality history including suicide**
- **Medical diagnoses and treatment**

Developmental and Social History

The developmental and social history reviews the stages of the patient's life.

The Developmental History should include:

- Maternal history of pregnancy
- Adverse perinatal events
- Birthing history
- Developmental milestones
- Childhood home environment including members of the family
- Number and quality of friends
- School history – how far the patient went and how old was the patient at that level
- Special education circumstances
- Learning disabilities/disorders
- Behavioral problems at school
- Academic performance
- Extracurricular activities
- Childhood physical or sexual abuse

Developmental and Social History Continued

Frequently, current psychosocial stressors will be revealed in the course of obtaining a social history.

Work History

- Jobs
- Performance and reasons for changing jobs
- Current work status
- Relationships with supervisors and coworkers
- Financial concerns regarding income, insurance coverage, and pharmacy benefits

Military History

- Rank achieved
- Combat exposure
- Disciplinary actions
- Discharge status

Marriage and Relationship History

- Current family structure
- Sexual preferences
- Current relationships with parents, grandparents, siblings, children, and grandchildren
- Friends

Legal History

- Pending charges or lawsuits

Hobbies, interests, pets, and leisure activities

Cultural and religious influences

Aspects to Include in the Developmental and Social History for the Child/Adolescent

Development proceeds along a predictable pathway marked by milestones. As children mature and develop at different rates, development may further be affected by factors such as abuse or poverty.

Include in the psychiatric evaluation:

- Relevant birth and infancy history – temperament, motor development
- Cognitive development – school performance, milestones
- Emotional development – self-esteem, self efficacy, sense of right/wrong
- Losses, including divorce
- Abuse, including neglect
- Sexual activity, birth control, pregnancies
- Childhood illnesses
- Childhood psychiatric disorders, learning disabilities
- Secondary sexual characteristics – onset of puberty, onset of menses
- Parental pressures
- Sense of personal identity

Clues to Developmental/Behavioral Problems in Children

- Enuresis
- Night Terrors
- Thumb Sucking
- Frequent Tantrums
- Excessive Isolation
- Fire Setting
- Cruelty to Animals
- Frequent School Truancy

Functional Assessment

Assessing the degree to which an individual has the ability to perform the functions of the demands of his/her life.

Determines the impact of the illness on overall functioning

Used to differentiate depression from dementia in elderly patients

Used to track improvement or decline from the patient's baseline

Includes;

Activities of Daily Living (ADLs) – basic self-care skills – eating, bathing, dressing, toileting

Instrumental Activities of Daily Living (IADLs) – activities needed for independent functioning – shopping, cooking, taking medications, driving, housekeeping

Physical Exam:

Physical and Neurological Exam
Review of Systems
Vital Signs, laboratory and diagnostic results

Content Reviewed in Another Session

Mental Status Exam

The MSE explores all the areas of mental functioning and denotes evidence of signs and symptoms of mental illness

Components of the Mental Status Exam

- Appearance
- Behavior
- Motor Activity
- Speech
- Mood
- Affect
- Thought content
- Thought process
- Cognition
  - Alertness
  - Orientation
  - Attention/Concentration
  - Memory
  - Abstract Reasoning
  - Insight
  - Judgment

Mental Status Anatomy

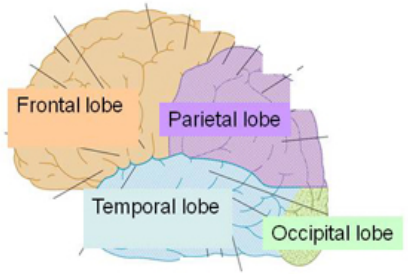


Figure 10-5. Lateral view of the left cerebral hemisphere, showing principle gyri and sulci. In: Waxman SG. *Clinical Neuroanatomy*. 26th ed. http://www.accessphysiotherapy.com. Accessed November 02, 2009.

The MSE includes cognitive screening – most often in the form of the Mini-Mental Status Examination-MMSE

The Mental Status Exam (MSE)

A key role function of the PMHNP is performing the MSE. It is the examiner's observations of the patient at the time of the interview. The MSE does not stand alone but is used in conjunction with the history, physical, diagnostic, and laboratory findings. The MSE is a systematic method of evaluating a patient's behavioral, emotional, and cognitive functioning.

The Goals of the MSE are

- To establish a baseline of the patient's emotional and cognitive functioning
- To identify a patient's behavioral and psychiatric needs
- To monitor a patient's functioning and symptom levels over time
- To function as a screening tool for at risk patients
- To readily identify patients experiencing psychotic symptoms

Mnemonic for Components of the MSE:
All **B**orderline **S**ubjects **A**re **T**ough, **T**roubled **C**haracters:
Appearance, **B**ehavior, **S**peech, **A**ffect, **T**hought process, **T**hought content, **C**ognitive examination (Carlat, 2012)

Appearance

A person's appearance can provide useful clues into their quality of self-care, lifestyle, and daily living skills.

This section consists of a general description of how the patient looks and acts during the interview. Does the patient appear to be his or her stated age, younger or older? Is this related to the patient's style of dress, physical features, or style of interaction?

Items to be noted include what the patient is wearing, including body jewelry, and whether it is appropriate for the context. Distinguishing features, including disfigurations, scars, and tattoos, are noted. Grooming and hygiene also are included in the overall appearance and can be clues to the patient's level of functioning. Assess the patient's posture and mannerisms.

Hygiene: clean, body odor, shaven, grooming
Dress: clean, dirty, neat, ragged, climate appropriate — anything unusual?
Jewelry: rings, earrings — anything unusual?
Makeup: lipstick, nail polish, eye makeup — anything unusual?
Other: prominent scars, tattoos

Behavior

The description of a patient's behavior includes a general statement about whether he or she is exhibiting acute distress and then a more specific statement about the patient's approach to the interview.

Describe the general behavior and attitude of the patient.

The patient may be described as cooperative, agitated, disinhibited, disinterested, confrontational, evasive and so forth.

Was the patient friendly, indifferent, or apathetic?

Appropriateness is an important factor to consider in the interpretation of the observation.

Motor Activity

Motor activity may be described as normal, slowed (bradykinesia), or agitated (hyperkinesia). This can give clues to diagnoses (e.g., depression vs. mania) as well as confounding neurological or medical issues.

Gait, freedom of movement, any unusual or sustained postures, pacing, and hand wringing are described.

The presence or absence of any tics should be noted, as should be jitteriness, tremor, apparent restlessness, lip-smacking, and tongue protrusions. These can be clues to **adverse reactions or side effects of medications** such as tardive dyskinesia, akathisia, or parkinsonian features from antipsychotic medications or **suggestion of symptoms of illnesses such as attention-deficit/hyperactivity disorder** (Sadock, Sadock, and Ruiz, 2015).

Speech

The description of speech has great overlap with the description of thought process.

Elements considered include fluency, amount, rate, tone, and volume.

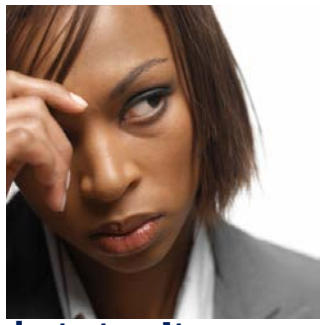
Fluency can refer to whether the patient has full command of the English language as well as potentially more subtle fluency issues such as stuttering, word finding difficulties, or paraphasic errors. **Descriptors** may also include slurred, clear, hesitant, or aphasic.

Amount of speech refers to whether it is normal, increased, or decreased. Decreased amounts of speech may suggest several different things ranging from anxiety or disinterest to thought blocking or psychosis. Increased amounts of speech often (but not always) are suggestive of mania or hypomania. **Descriptors** may include talkative, expansive, paucity, poverty (alogia)

Rate of speech. Is it slowed or rapid (pressured)? **Descriptors** may also include fast or normal.

Tone and volume can be described as loud, soft, monotone, weak, strong, mumbled.

Mood and Affect



Mood **is defined as the patient's internal and sustained emotional state. Its experience is subjective, and hence it is best to use the patient's own words in describing his or her mood. Terms such as "sad," "angry," "guilty," or "anxious" are common descriptions of mood.**

Affect is a variation of emotional expression in facial expression, body language, nonverbal communication, and voice intonation. Affect is recorded as the PMHNP's objective observation of the patient's state of emotions and is often described with the following elements: quality, quantity, range, appropriateness, and congruence.

Quality (or tone) of a patient's affect can be described as dysphoric, happy, euthymic, irritable, angry, agitated, tearful, sobbing, and flat.

Quantity of affect is a measure of its intensity mild or severe for example.

Range can be restricted, normal, or labile. *Flat* is a term that has been used for severely restricted range of affect that is described in some patients with schizophrenia

Appropriateness of affect refers to how the affect correlates to the setting.

Congruence or incongruent is also an element of affect which describes how the patient's described mood or thought content matches observed

Thought Content

Thought content is what the patient is thinking about. It includes ideas, obsessions, and preoccupations. Identifying abnormalities is essential to effective differential diagnosing for the patient.

Thought content may be inferred by what the patient spontaneously expresses, as well as responses to specific questions aimed at eliciting particular pathology.

Abnormalities in Though Content may include:

Hallucinations – false sensory perception without stimuli present – can be tactile, olfactory, gustatory, auditory, or visual – can be pervasive or episodic

Delusions - rigidly held false beliefs not consistent with the person's background

Overvalued ideas - unreasonable belief, e.g. a person with anorexia believing they are overweight

Preoccupations – somatic preoccupation with bodily functions, processes, and sensations not based on any realistic alteration in body function.

Self-harm, suicidal, aggressive or homicidal ideation

Obsessions - preoccupying and repetitive thoughts about a feared or catastrophic outcome, often indicated by associated compulsive behavior

Depersonalization or Derealization

Thought Process

Thought process describes how the patient's thoughts are formulated, organized, and expressed. Normal thought process is typically described as linear, organized, and goal directed.

A patient can have normal thought process with significantly delusional thought content.

A patient may have generally normal thought content but significantly impaired thought process.

Table 5.1-4
Formal Thought Disorders

Circumstantiality. Overinclusion of trivial or irrelevant details that impede the sense of getting to the point.

Clang associations. Thoughts are associated by the sound of words rather than by their meaning (e.g., through rhyming or assonance).

Derailment. (Synonymous with loose associations.) A breakdown in both the logical connection between ideas and the overall sense of goal directedness. The words make sentences, but the sentences do not make sense.

Flight of ideas. A succession of multiple associations so that thoughts seem to move abruptly from idea to idea; often (but not invariably) expressed through rapid, pressured speech.

Neologism. The invention of new words or phrases or the use of conventional words in idiosyncratic ways.

Perseveration. Repetition of out of context words, phrases, or ideas.

Tangentiality. In response to a question, the patient gives a reply that is appropriate to the general topic without actually answering the question. Example:
Doctor: "Have you had any trouble sleeping lately?"
Patient: "I usually sleep in my bed, but now I'm sleeping on the sofa."

Thought blocking. A sudden disruption of thought or a break in the flow of ideas.

Cognition

The elements of cognitive functioning that should be assessed in the Psychiatric Interview includes:

- Alertness
- Orientation
- Attention/Concentration
- Memory – both short and long-term
- Abstract Reasoning
- Insight
- Judgment

Alertness and Orientation

Level of alertness: Is the patient conscious? If not, can they be aroused? Can they remain focused on your questions and conversation?

Awareness of environment, also referred to as **orientation:** Do they know where they are and what they are doing here? Do they know who you are? Can they tell you the day, date and year?

Person, place, time, situation

Attention and Concentration

Attention – Is the patient attentive or distractible? These are clinician observations about the level of distractibility.

Concentration – Performance on a mentally effortful task – such as:

Serial Sevens is counting down from one hundred by sevens, is a clinical test used to test mental function. On its own, the inability to perform 'serial sevens' is not diagnostic of any particular disorder or impairment, but is generally used as a quick and easy test of concentration and memory.

Backward-spelling Testing - can test attention by seeing if the patient can remain focused on a simple task, such as spelling a short word forward and backward (W-O-R-L-D / D-L-R-O-W is a s standard).

Memory

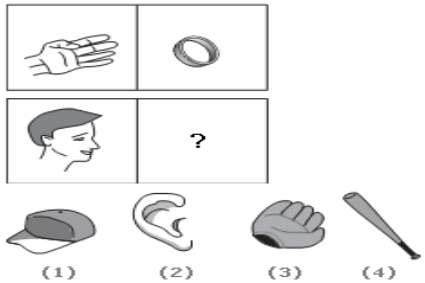
To assess for impairment in memory, clinicians can use:

Short-term memory testing state the name of three unrelated items (dog, pencil, ball) and then ask the patient to repeat the three items. This is testing their "short term or working memory".

Recent memory testing –ask the patient to remember the three items stated above, because you will ask him/her to repeat them 3-5 minutes later. Make certain all three objects have been registered and provide distracters during the delay period to prevent the patient from rehearsing the items repeatedly. Then, (after 3-5 minutes), ask your patient to recall the three unrelated items. This is testing what is called "recent memory".

Remote memory testing asking the patient about historical or verifiable personal events of the past.

Abstract Reasoning



- Abstract reasoning is the ability to shift back and forth **between general concepts and specific examples.**
- Having the patient identify **similarities** between like objects or concepts (apple and pear, bus and airplane, or a poem and a painting) as well as **interpreting proverbs** can be useful in assessing one's ability to abstract.
- Cultural and educational factors and limitations should be kept in mind when assessing the ability to abstract.
- Occasionally, the inability to abstract or the idiosyncratic manner of grouping items can be dramatic.

Insight and Judgment

Insight refers to the patient's understanding of how he or she is feeling, presenting, and functioning as well as the potential causes of his or her psychiatric presentation. Insight can be described as no insight, partial insight, or full insight.

- A component of insight often is **reality testing** in the case of a patient with psychosis.
- An example of **intact reality testing** would be, "I know that there are not really little men talking to me when I am alone, but I feel like I can see them and hear their voices."
- The **amount of insight is not an indicator of the severity of the illness** as a person with psychosis may have good insight, while a person with a mild anxiety disorder may have little or no insight.

Judgment refers to the person's capacity to make good decisions and act on them. The level of judgment may or may not correlate to the level of insight.

- A patient may have no insight into his or her illness but have good judgment.
- It is better to use real situations from the patient's own experience to test judgment.
- The important issues in assessing judgment include whether a patient is doing things that are dangerous or going to get him or her into trouble and whether the patient is able to effectively participate in his or her own care.

Formulation/Impressions, Differentials, and DSM 5 Diagnosis

Impressions are developed throughout the interview as new hypotheses are created and tested by further data that are elicited.

The PMHNP considers the patient's history, presentation, and current status as well as biological factors (medical, family, and medication history), psychological factors such as childhood circumstances, upbringing, and past interpersonal interactions, and social factors including stressors, and contextual circumstances such as finances, school, work, home, and interpersonal relationships.

These considerations viewed as a whole, should lead to a **differential diagnosis** of the patient's illness as well as a provisional **diagnosis**.

The clinician will include in this overall impression a **safety assessment**, which contributes to the determination of level of care recommended or required.

Treatment Planning

If a treatment plan is being initiated, then the structure of that treatment should be discussed. Will the main focus be on medication management, psychotherapy, or both? What will the frequency of visits be? How will the clinician be paid for service and what are the expectations for the patient to be considered engaged in treatment?

Medication recommendations should include a discussion of possible therapeutic medications, the **risks and** benefits of no medication treatment, and **alternative treatment** options.

The prescriber must obtain **informed consent** from the patient for any medications (or other treatments) initiated.

Treatment Planning (continued)

Other clinical treatment recommendations may include referral for psychotherapy, group therapy, chemical dependency evaluation or treatment, medical assessment, or there also may be recommended psychosocial interventions including case management, group home or assisted living, social clubs, support groups such as a mental health alliance, the National Alliance for the Mentally Ill, and AA.

Collaboration with primary care doctors, specialists, or other clinicians should always be a goal.

Family involvement in a patient's care can often be a useful and integral part of treatment and requires proper patient consent.

Discussion of **safety planning** and contact information should occur during the psychiatric interview. The clinician's contact information as well as after-hours coverage scheme should be reviewed.

The patient needs to be informed of what he or she should do in the **case of an emergency**, including using the emergency room or calling 911 or crisis hotlines that are available.

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