Module 2, Part 1: The Psychiatric Interview

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Fundamentals of Interviewing

- Skills required for an effective and comprehensive psychiatric interview:
  - openness
  - respect for the patient and the family
  - appropriate use of therapeutic communication
  - ability to establish rapport
  - subjective and object if data collection using all senses
  - critical thinking
- The psychiatric interview is a focused, goal directed, interaction TLE 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

Characteristics of an Effective Relationship

- An effective relationship with the patient will assist the PMHMP in this important process. To develop an effective relationship, the PMHMP strives to:
  - learn about the patient's motivation and interest for care
  - have an open and respectful engagement utilizing a nonjudgmental 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 concerns can be addressed
  - develop a sense of partnership with the patient and the family

Background

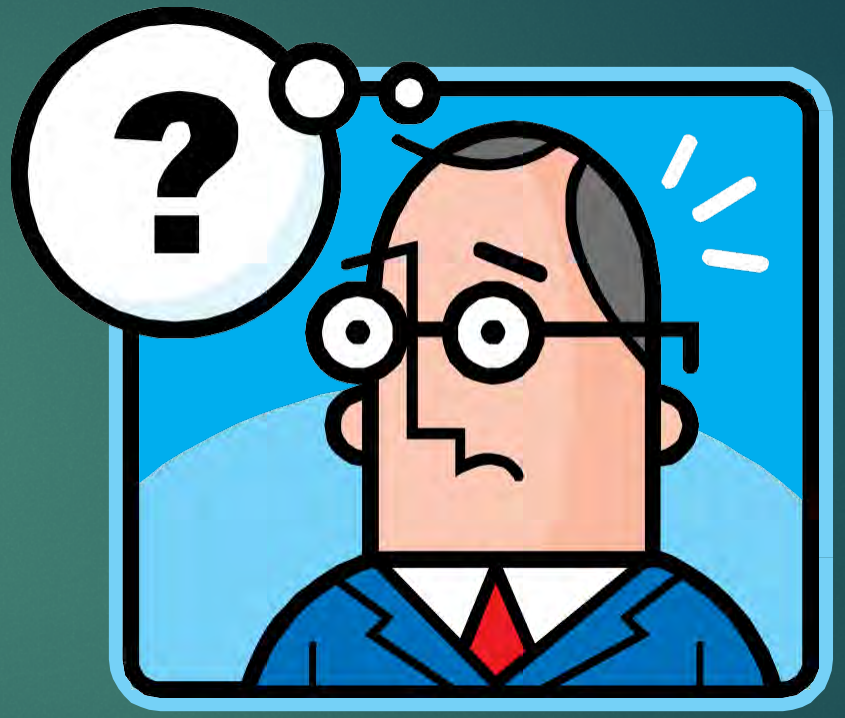
- The comprehensive psychiatric assessment is one of the most important diagnostic tools a psychiatric provider has to obtain information to make an accurate diagnosis.
- A thorough and accurate psychiatric assessment is necessary in order to formulate a proper diagnosis for your patient.
- Each component of the psychiatric assessment serves a purpose and must be completed with as much accuracy as possible.

Demographics

- Think of the demographic section as an introduction. An introduction is necessary to establish the focus of this case and provide information and orientation to the reader.
- This section consists of a few clear and concise opening statements which typically include information on:
  - Name (But in the case of your paper, "the patient")
  - Age
  - Marital status
  - Occupation
  - Referral details
  - Insurance and other pertinent information

Chief Complaint

- This is the patient's problem or reason for the visit. Most often, this is recorded as the patient's own words, in quotation marks.
- This statement allows identification of the problem by identifying symptoms that lead to a diagnosis and, eventually, a specific treatment plan.
- To elicit this response, the interviewer should ask leading questions such as "What brings you here today?"



History of Present Illness

- This should be a detailed account of the patient's chief complaint that you have identified in the opening statement, recorded in chronological order.
- Identify common psychiatric symptoms and should make connections between the isolated symptoms that the patient may have revealed to you somewhat randomly during the interview by grouping the symptoms together. It may be necessary to record relevant negative as well as positive symptoms.
- Comment on the impact of the illness on the patient's life. Consider work, social relations, and self-care.
- Note details of previous treatment. Include information on who administered the treatment, what the treatment was, the duration of treatment, and the patient's response to the treatment.

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 noted until the present time should be narrated chronologically, in a coherent manner.
- Include any other changes that have occurred during the same time period in the patient's interests, interpersonal relationships, behaviors, personal habits, and physical health.

Information to Ascertain the HPI

- Onset of symptoms including a list of symptomology. Is this a new compliant? How long is 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?

Past Psychiatric History

- Many psychiatric illnesses are recurrent and have exacerbations and remissions. The link between the present illness in the past psychiatric history may provide insight into a proper diagnosis.
- Points to address in this section include:
  - Details of previous episodes of illness
  - Previous psychiatric admissions and treatments
  - Outpatient community treatments
  - Suicide attempts, drug and alcohol abuse, and other self destructive behaviors.
  - Interval functioning (what the patient is light between episodes; when they consider themselves to be well)

Past Psychiatric History

- List all of the patient's treatment, including outpatient, inpatient, and therapy-based (ie, individual, couples, family, group), including dates.
- Inquire about past psychotropic medications and response, compliance, and dosages.
- Ask patients if they feel that they received any benefits from the treatments. If so, inquire about the specific type of benefit. Additionally, ask patients which medications they feel helped them most in the past and ask which ones helped them least.
- By including this type of information, you will build a picture of the pattern of illness. This will contribute to an appropriate diagnosis.

To Ascertain the Past Psychiatric History

- Ask the following questions to ascertain the past psychiatric history:
  - Have you ever been admitted to a psychiatric hospital?
  - What treatments have you had?
  - Has there ever been a time when you felt completely well?
- 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**

Lethality History

- 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.

Past Medical History

- List medical problems, both past and present, and all medical illnesses. At least ask a few screening questions regarding medical illnesses such as do you see a doctor regularly.
- If possible, try to review the patient's entire medical record rather than depending solely on the patient's self-report. Even the most minute detail of a patient's medical history, from as far back as childhood, could play a significant role in the presenting problem.
- Be certain to inquire about specific events that may have occurred in childhood, such as falls, head trauma, seizures, and injuries with loss of consciousness. All of these could be relevant to their current problems.

Past Medical History

- List all surgical procedures the patient has undergone, including dates.
- List the patient's current medications, including dosages, route, regimen, and whether or not the patient has been compliant. If possible, have the patient bring his or her medications to the visit.
- Also, inquire about past medications. Additionally, with all past medications, look for signs or patterns of noncompliance. Ask the patient who prescribed the medications and when or why the patient discontinued taking them.
- List all drug and food allergies the patient currently has or has had in the past, and list what type of reactions the patient had to the medications.

Medical and Psychiatric Illness Correlation

- 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).

Family History

- List any psychiatric or medical illnesses, including method of treatment such as hospitalization (medical and psychiatric) of family members and response.
- Once again, the emphasis here is strong. Record any information obtained because it may help in treatment planning.
- If a patient's family member has been diagnosed with the same psychiatric illness and has been treated successfully, treating the current patient with that same medication may be appropriate.

Familial-Linked Disorders

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).

Personal/Social History

- This is important when planning care as well as determining symptoms of illness.
- Sleep patterns, eating habits, dietary practices, and self-care practices can provide insight into a variety of psychiatric symptoms
- This addition to the patient history can be most crucial when discharge planning begins. Inquire if the patient has a home. Also ask if the patient has a family, and, if so, if the patient maintains contact with them.

Personal/Social History (cont)

- Ask patients their marital status and employment status. If the patient is employed, inquire about the frequency of absences from work.
- If the patient is not employed, inquire about whether the patient currently is looking for work. Also inquire if a previously held job was lost as a result of the illness. Obtain as much detailed information as possible.
- Information obtained from the patient's social history may aid in making special accommodations for the patient when necessary. This would include an accurate record of the last grade completed in school, whether the patient was in special education classes, or if the patient required special assistance at work or school (ie, special listening devices for the hard of hearing).

Social History

- Work History:
  - Jobs
  - performance and reason for changing jobs
  - current work status
  - relationship with supervisors and coworkers
  - financial concerns regarding income, insurance coverage
- Legal history:
  - Pending charges or lawsuits
- Medical history:
  - rank achieved
  - combat exposure
  - disciplinary actions
  - discharge status
- Marriage and relationship history:
  - current family structure
  - sexual preferences
  - current relationships with family members
  - Friends

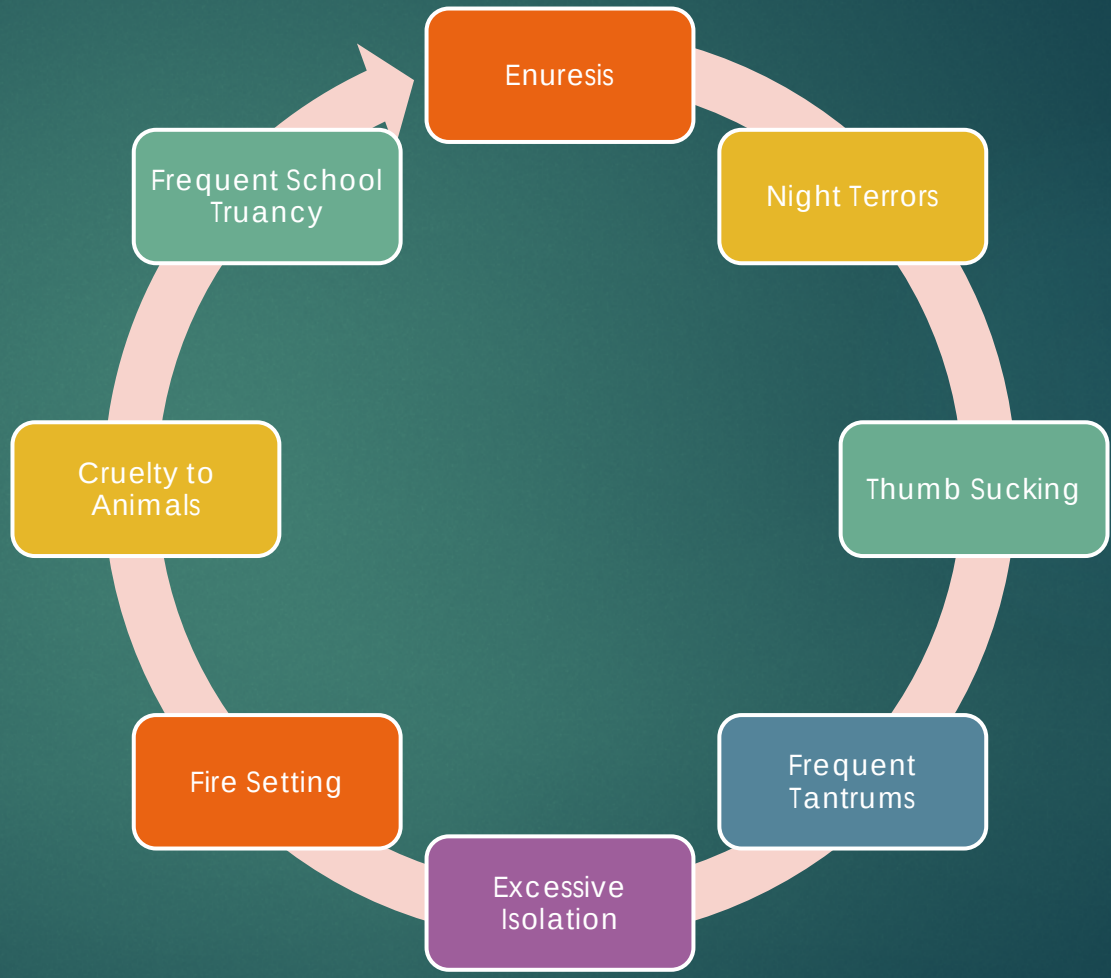
Developmental History Should Include…

- 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
- hobbies, interests, pets, and leisure activities
- cultural and religious influences

Developmental and Social History of Child/Adolescent

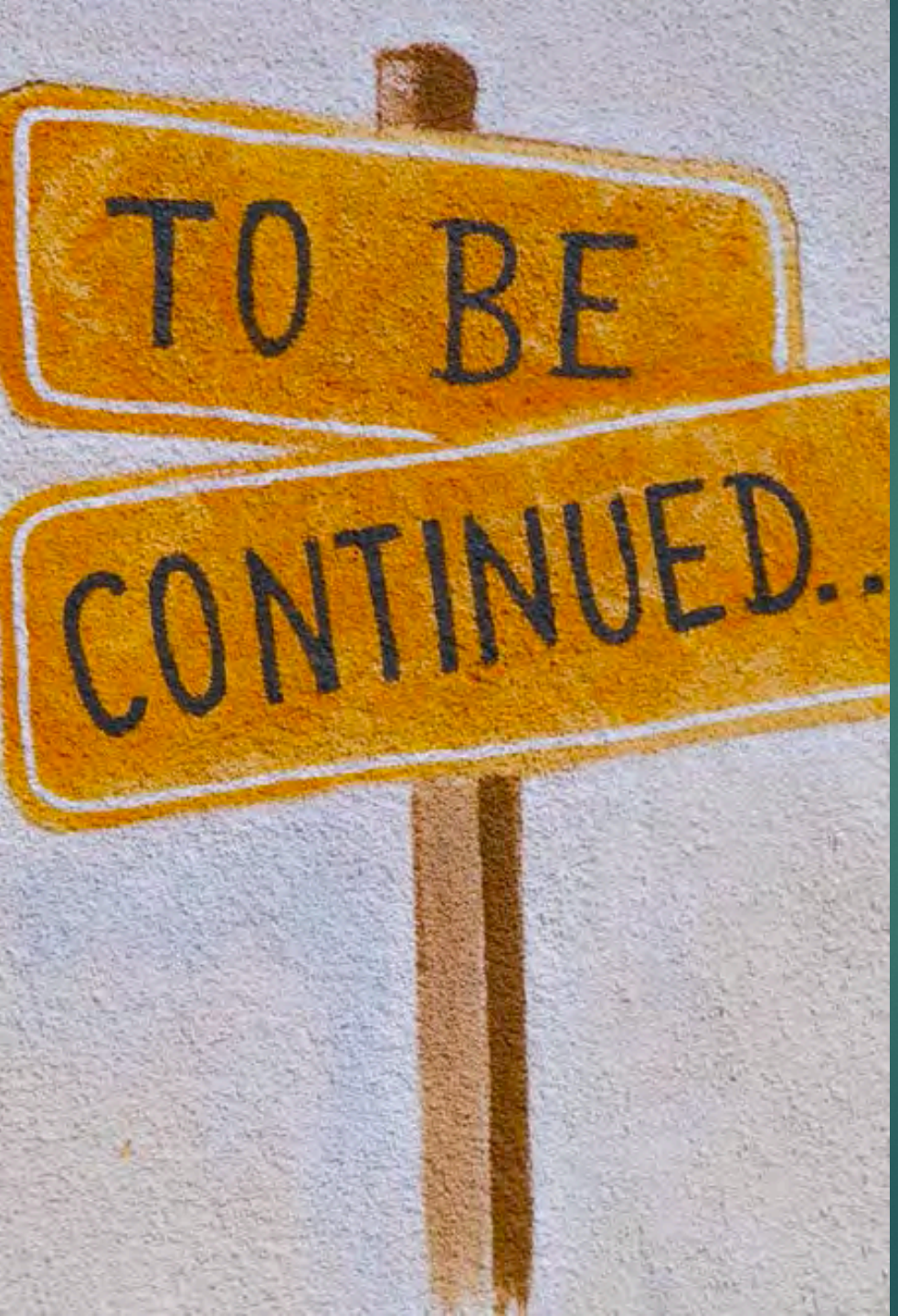
- Include in the psychiatric evaluation:
- Relevant birth and infancy history – temperament, motor development
- Cognitive development – school performance, milestones
- Emotional development – self-esteem, self efficacy, sense of right/wrong
- Losses, including divorce
- Abuse, including neglect
- Sexual 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 Problems in Children



Educational History

- Recording an accurate educational history is imperative. Inquire how far the patient went in school. Ask if he or she was in special education classes.
- Ask if the patient has a learning disability and if the patient has any other problem such as a hearing impairment or speech problem.
- These issues are very important in the evaluation of patients undergoing psychiatric assessment, and patient care could be jeopardized if they are not addressed. A patient's communication problems, for example, could be due to a language disorder rather than a thought disorder, and the initiation of psychiatric medications could further affect communication.



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