Module 2, Part 2: The Psychiatric Interview

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Substance Use History

- List the patient's toxic habits, including past and current use of tobacco, alcohol, and street drugs. Remember to include use of energy drinks in adolescents and OTC medications.
- If not obvious, determine how they pay for their “habits”.
- Also in the history section, record any legal problems the patient may have had in the past. This should include jail time, probation, arrests (e.g., for driving while intoxicated or driving under the influence of drugs), and any other relevant information that can provide insight into the patient's problems with the law.

Substance Use Patterns

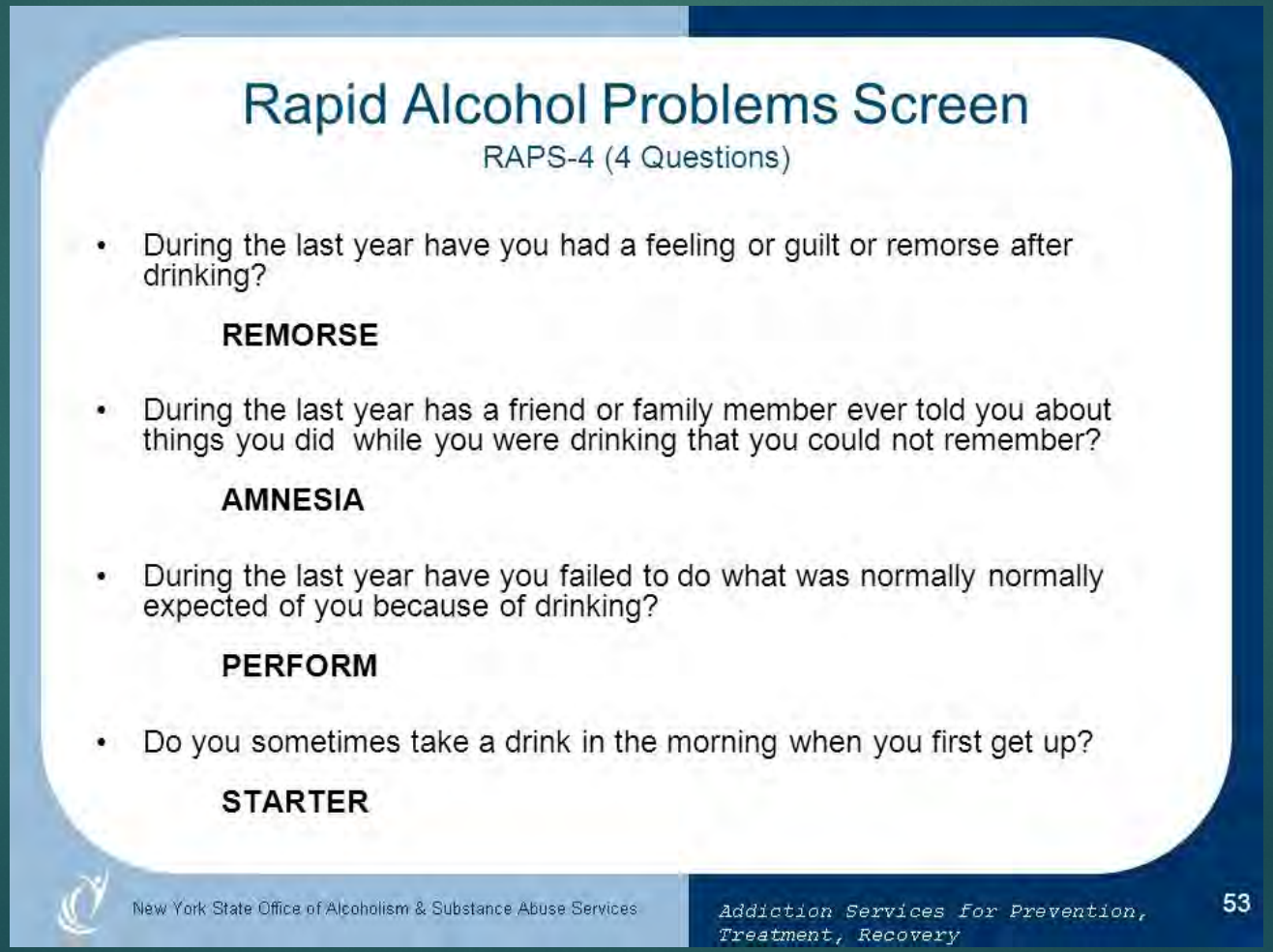
- Any periods of sobriety should be noted including links of time and setting such as in jail, legally mandated, and so forth.
- A history of treatment episodes should also be explored, including inpatient detoxification or rehabilitation, outpatient treatment, group therapy, or other settings including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

Screening for Alcohol Abuse

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		

Screening for Alcohol Dependence



Substance Use, Abuse, and Addictions

- 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 views on social, occupational, or school domains
  - legal consequences

Personal/Social History (cont)

- Patient history also should include hobbies, social activities, and friends. If the patient has any history of abuse, mental or physical, it should be recorded here. Any other relevant information that may be useful in treating the patient or helpful in aiding in aftercare should be recorded in the patient history.
- Inquire about the patient's and the patient's parents' religious beliefs. Did the patient grow up in a strict religious environment? Does the patient have a particular religious belief and has that changed since childhood, adolescence, or adulthood? Investigate what effect the patient's beliefs have on treatment of psychiatric illnesses or suicide.

Sexual History

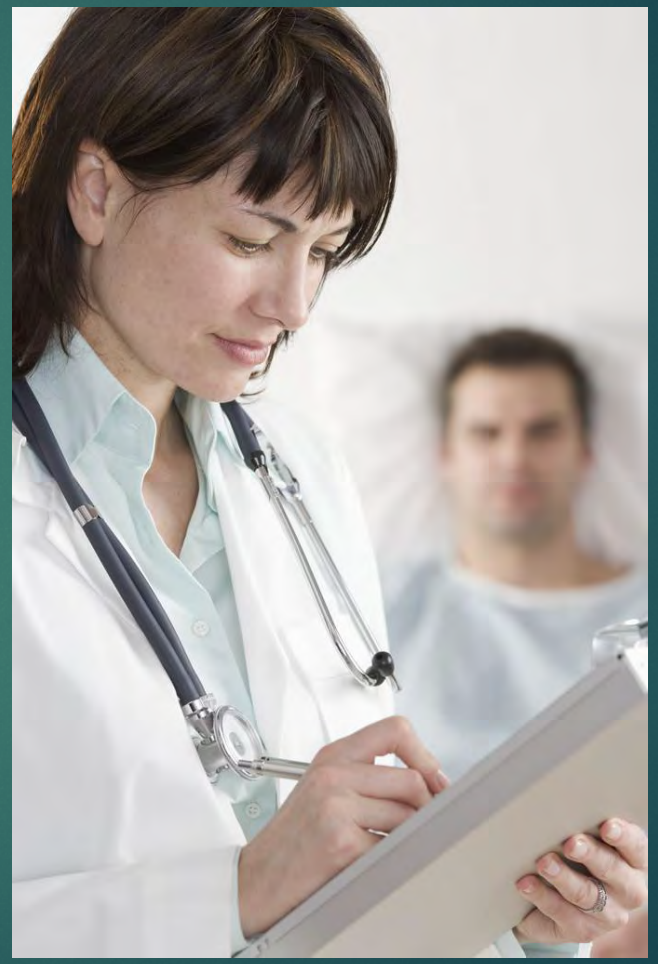
- Approaching essential history might vary with different patient populations. Social history should be augmented with questions related to psychological health and special high-risk groups where appropriate.
- Some patients may be reluctant to answer your questions regarding sexual history; however, it is important to help them understand that this is necessary to obtain information pertinent to their care.
- The social history would include:
  - View of gender
  - Practices
  - Fantasies or dreams
  - Sexual preferences
  - Beliefs about sexuality

Functional Assessment

- Assessing the degree to which an individual has the ability to perform the functions of the demands of his or 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

Review of Systems

- It is important to determine if there is a medical cause for the patient's psychiatric symptoms. The medical ROS provides a foundation for further investigation to rule out an organic cause prior to initiating psychotropic therapy.



Mental Status (Appearance)

- Record the patient's sex, age (apparent and stated), race, and ethnic background. Document the patient's nutritional status by observing the patient's current body weight and appearance.
- Recall how the patient first appeared upon entering the office for the interview. Note whether this posture has changed. Note whether the patient appears more relaxed. Record the patient's posture and motor activity.
- Record the patient's dress, grooming, and hygiene.
- Record whether the patient has maintained eye contact throughout the interview or if he or she has avoided eye contact as much as possible, scanning the room or staring at the floor or the ceiling.

Mental Status (Reliability)

- Estimate the patient's reliability.
- Determine if the patient seems reliable, unreliable, or if it is difficult to determine.
- This determination requires collateral information of an accurate assessment, diagnosis, and treatment.

Sample

- The client has difficulty with memory and concentration. On several occasions, questions were repeated. However, information she offered was consistent with previous information obtained, and verified by her previous records.

Mental Status (Attitude & Behavior)

- Next, record the patient's facial expressions and attitude toward the examiner. Note whether the patient appeared interested during the interview or, perhaps, if the patient appeared bored.
- Record whether the patient is hostile and defensive or friendly and cooperative. Note whether the patient seems guarded and whether the patient seems relaxed with the interview process or seems uncomfortable.
- This part of the examination is based solely on observations made by the health care professional.

Sample

- She came into the room and sat in the chair facing the interviewer. She had poor eye contact and was constantly looking down towards the ground. She was tearful at times. She had poor posture and was slumped over sitting Indian style in the chair. The patient was minimally cooperative, but vague and guarded with her responses. She expressed feelings of guilt due to having to be readmitted and was concerned about how the provider felt that she was back.

Mental Status Exam (Speech)

- Document information on all aspects of the patient's speech, including quality, quantity, rate, and volume of speech during the interview.
- Paying attention to patients' responses to determine how to rate their speech is important.
- Some things to keep in mind during the interview are whether patients raise their voice when responding, whether the replies to questions are one-word answers or elaborative, and how fast or slow they are speaking.
- Record the patient's spontaneous speed in relation to open-ended questions.

Mental Status Exam (Affect)

- A patient's affect is defined in the following terms: expansive (contagious), euthymic (normal), constricted (limited variation), blunted (minimal variation), and flat (no variation).
- A patient whose mood could be defined as expansive may be so cheerful and full of laughter that it is difficult to refrain from smiling while conducting the interview.
- A patient's affect is determined by the observations made by the interviewer during the course of the interview.
- The patient's affect is noted to be inappropriate or non-congruent if no connection is clear between what the patient is saying and the emotion being expressed.

Mental Status Exam (Mood)

- The mood of the patient is defined as "sustained emotion that the patient is experiencing."
- Ask questions such as "How do you feel most days?" to trigger a response. Helpful answers include those that specifically describe the patient's mood, such as "depressed," "anxious," "good," and "tired."
- Elicited responses that are less helpful in determining a patient's mood adequately include "OK," "rough," and "don't know." These responses require further questioning for clarification.
- Establishing accurate information pertaining to the length of a particular mood, if the mood has been reactive or not, and if the mood has been stable or unstable also is helpful.

Mental Status (Thought Process)

- Record the patient's thought process information. The process of thoughts can be described with the following terms:
  - looseness of association (irrelevance),
  - flight of ideas (change topics),
  - racing (rapid thoughts),
  - tangential (departure from topic with no return),
  - circumstantial (being vague, i.e., "beating around the bush"),
  - word salad (nonsensical responses, i.e., jabberwocky),
  - derailment (extreme irrelevance),
  - neologism (creating new words),
  - clanging (rhyming words),
  - punning (talking in riddles),
  - thought blocking (speech is halted), and
  - poverty (limited content).

Mental Status (Thought Process)

- Throughout the interview, very specific questions will be asked regarding the patient's history.
- Note whether the patient responds directly to the questions. For example, when asking for a date, note whether the response given is about the patient's favorite color.
- Document whether the patient deviates from the subject at hand and has to be guided back to the topic more than once.
- Take all of these things in to account when documenting the patient's thought process.

Sample

- **Speech:** Her speech was soft and mumbled. She spoke at a normal rate, not pressured or slow. She did have mild latency of response.
- **Affect and Mood:** The patient feels that her mood has been sad and irritable. Her affect is flat and blunted, which is congruent. She had a full range of affect throughout the interview.
- **Thought Processes:** Her thought processes are coherent, linear, logical, and goal-directed. She does not have racing thoughts, looseness of associations, or flight of ideas.

Mental Status (Thought Content)

- To determine whether or not a patient is experiencing hallucinations, ask some of the following questions. "Do you hear voices when no one else is around?" "Can you see things that no one else can see?" "Do you have other unexplained sensations such as smells, sounds, or feelings?"
- Importantly, always ask about command-type hallucinations and inquire what the patient will do in response to these commanding hallucinations. For example, ask "When the voices tell you do something, do you obey their instructions or ignore them?" Types of hallucinations include auditory (hearing things), visual (seeing things), gustatory (tasting things), tactile (feeling sensations), and olfactory (smelling things).

Thought Content

- To determine if a patient is having delusions, ask some of the following questions. "Do you have any thoughts that other people think are strange?" "Do you have any special powers or abilities?" "Does the television or radio give you special messages?"
- Types of delusions include grandiose (delusions of grandeur), religious (delusions of special status with God), persecution (belief that someone wants to cause them harm), erotomanic (belief that someone famous is in love with them), jealousy (belief that everyone wants what they have), thought insertion (belief that someone is putting ideas or thoughts into their mind), and ideas of reference (belief that everything refers to them).

Aspects of Thought Content

- ***Obsession and compulsions:*** Ask the following questions to determine if a patient has any obsessions or compulsions. "Are you afraid of dirt?" "Do you wash your hands often or count things over and over?" "Do you perform specific acts to reduce certain thoughts?" Signs of ritualistic type behaviors should be explored further to determine the severity of the obsession or compulsion.
- ***Phobias:*** Determine if patients have any fears that cause them to avoid certain situations. The following are some possible questions to ask. "Do you have any fears, including fear of animals, needles, heights, snakes, public speaking, or crowds?"

Aspects of Thought Content

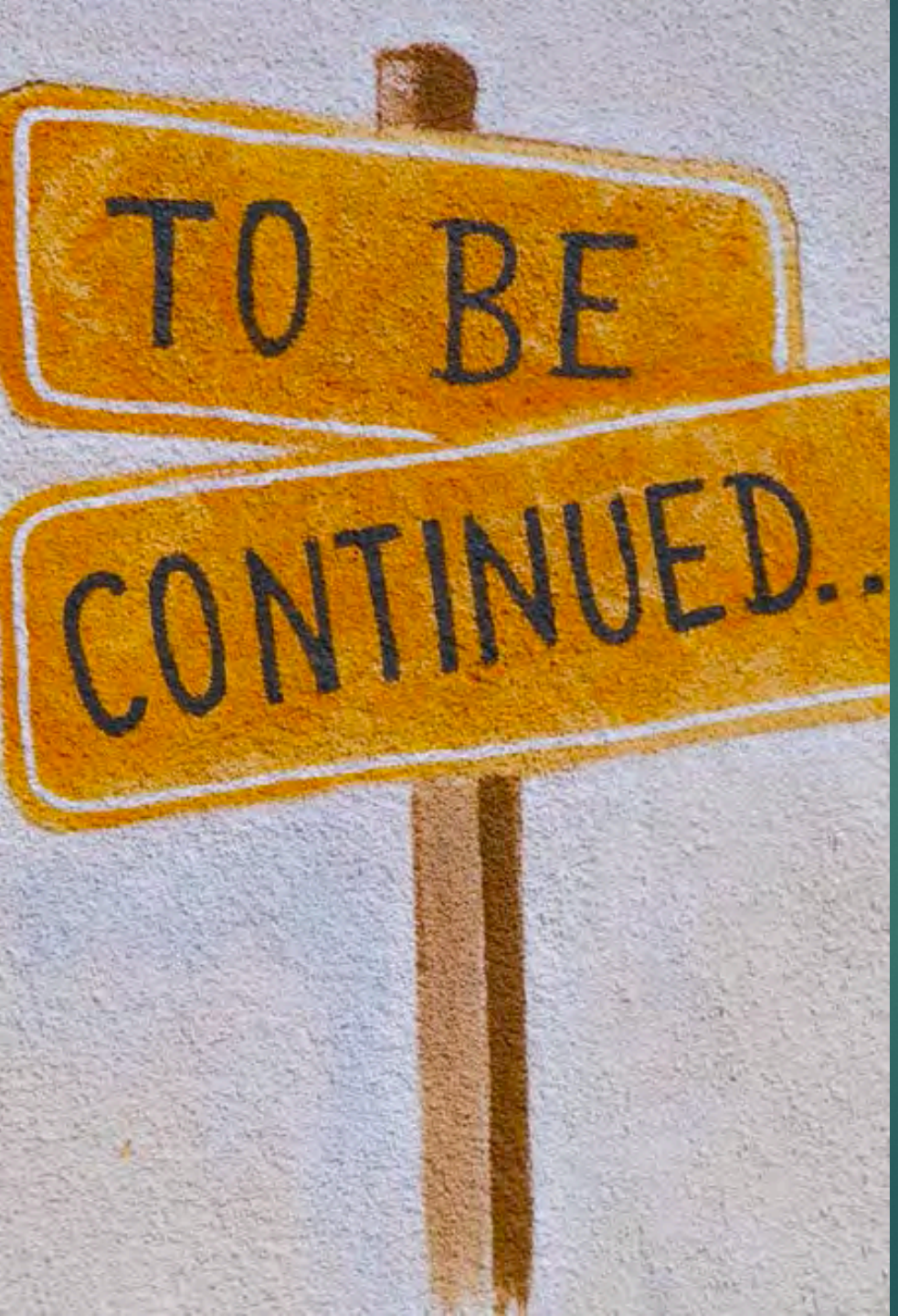
- ***Suicidal ideation or intent***: Inquiring about suicidal ideation at each visit is always important. In addition, the interviewer should inquire about past acts of self-harm or violence.
- Ask the following types of questions when determining suicidal ideation or intent. "Do you have any thoughts of wanting to harm or kill yourself?" "Do you have any thoughts that you would be better off dead?"
- If the reply is positive for these thoughts, inquire about specific plans, suicide notes, family history (anniversary reaction), and impulse control. Also, ask how the patient views suicide to determine if a suicidal gesture or act is ego-syntonic or ego-dystonic.

Aspects of Thought Content

- ***Homicidal ideation or intent:*** Inquiring about homicidal ideation or intent during each patient interview also is important.
- Ask the following types of questions to help determine homicidal ideation or intent. "Do you have any thoughts of wanting to hurt anyone?" "Do you have any feelings or thoughts that you wish someone were dead?"
- If the reply to one of these questions is positive, ask the patient if he or she has any specific plans to injure someone and how he or she plans to control these feelings if they occur again.

Sample

- Her son reports that the patient is calling to her late husband at night. The patient denies hallucinations or ideas of reference. She denies paranoia. She admits feeling confused sometimes and admittedly obsessing over her daughter's recent departure from home, and uncertainty over her financial situation. She has thoughts of death, but not suicide, tearfully stating “I wouldn't do that.” She feels worthless, and hopeless. She denies compulsions, rituals or phobias. Her son reports confusion at night, with statements made that she is seeing her dead husband.



Please proceed to Part 3 of this presentation