# 05 - Chapter 2 Examination and Diagnosis

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10 EXAMINATION AND DIAGNOSIS WARDS TIP INTERVIEWING The history of present illness (HPI) should include information about the current episode, including symptoms, duration, context, stressors, and impairment in function. WARDS TIP If you are seeing the patient in the ER, make sure to ask how they got to the ER (police, bus, walk-in, family member) and look to see what time they were triaged. For all initial evaluations, ask why the patient is seeking treatment today as opposed to any other day. Date and Location: Identifying Patient Data: Chief Complaint: WARDS TIP History of Present Illness: When taking a substance history, remember to ask about caffeine and nicotine use. If a heavy smoker is hospitalized and does not have access to nicotine replacement therapy, nicotine withdrawal may cause anxiety and agitation. Past Psychiatric History: First contact: Diagnosis: Prior hospitalizations: Suicide attempts: Outpatient treatment: Med trials: Substance History: Smoking: Family Psychiatric History: Legal History: FIGURE 2-1. Psychiatric history outline. History and Mental Status Examination Making the Patient Comfortable The initial interview is of utmost importance to the psychiatrist. With practice, you will develop your own style

and learn how to adapt the interview to the individual patient. In general, start the interview by asking open-ended questions. Carefully note how the patient responds, as this is critical information for the mental status exam. Consider preparing for the interview by writing down the subheadings of the exam (see Figure 2-1). Find a safe and private area to conduct the interview. Use closed-ended questions to obtain the remaining pertinent information. During the first interview, the psychiatrist must establish a meaningful rapport with the patient in order to get accurate and pertinent information. This requires that the questions be asked in a quiet, comfortable setting so that the patient is at ease. The patient should feel that the psychiatrist is interested, nonjudgmental, and compassionate. In psychiatry, the history is the most important factor in formulating a diagnosis and treatment plan. Past Medical History: Allergies: Current Meds: Developmental History: Relationships (children/marital status): Education: Work History: Military History: Housing: Income: Religion:

TAKING THE HISTORY The psychiatric history follows a similar format as the history for other types of patients. It should include the following: n Identifying data: The patient's name, preferred gender, age, marital status. n Chief complaint (use the patient's own words): If called as a consultant, list reason for the consult. n Sources of information. n History of present illness (HPI): • The 4 Ps: The patient's psychosocial and environmental conditions predisposing to, precipitating, perpetuating, and protecting against the current episode. • The patient's support system (whom the patient lives with, distance and level of contact with friends and relatives). • Neurovegetative symptoms (quality of sleep, appetite, energy, psychomotor retardation/activation, concentration). • Suicidal ideation/homicidal ideation. • How work and relationship have been affected (for most diagnoses in the Diagnostic and Statistical Manual of Mental Disorders, 5th edition [DSM-5] there is a criterion that specifies that symptoms must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning). • Psychotic symptoms (e.g., auditory and visual hallucinations, delusions). • Establish a baseline of mental health:

- Patient's level of functioning when "well."
- Goals (outpatient setting). n Past psychiatric history (include as applicable: history of suicide attempts, history of self-harm [e.g., cutting, burning oneself], information about previous episodes, other psychiatric disorders in remission, medication trials, past psychiatric hospitalizations, current outpatient psychiatrist). n Substance history (age of first use, amount and route of use, history of withdrawal/delirium tremens (DTs), longest period of sobriety, history of intravenous drug use, participation in outpatient or inpatient drug rehab programs). n Medical history (ask specifically about head trauma, seizures, pregnancy status). n Family psychiatric and medical history (include substance use, suicides, and response to specific psychotropic agents as patient may respond similarly). n Medications (ask about supplements and over-the-counter [OTC] medications, as well as compliance). n Allergies: Clarify if it was a true allergy or an adverse drug event (e.g., abdominal pain). n Developmental/Social history: Achieved developmental milestones on time, friends in school, history of trauma or abuse, performance academically. Also include income source, employment, education, place of residence, who they live with, number of children, support system, religious affiliation and beliefs, legal history, and amount of exercise. EXAMINATION AND DIAGNOSIS WARDS QUESTION Q: What OTC medication would be important to ask and document in a patient with bipolar disorder taking Lithium. A: Nonsteroidal anti-inflammatory drugs (NSAIDs) as they can ↑ lithium

concentrations.

12 EXAMINATION AND DIAGNOSIS MENTAL STATUS EXAMINATION WARDS TIP Psychomotor retardation, which refers to the slowness of voluntary and involuntary movements, may also be referred to as hypokinesia or bradykinesia. The term akinesia is used in extreme cases where absence of movement is observed. n Appearance/Behavior n Speech n Mood/Affect n Thought process n Thought content n Perceptual disturbances n Cognition n Insight KEY FACT Automatisms are spontaneous, involuntary movements that occur during an altered state of consciousness and can range from purposeful to disorganized. Appearance/Behavior WARDS QUESTION Q: What is pressured speech? A: Speech that is usually uninterruptible with the patient compelled to continue speaking. WARDS TIP To assess mood, ask, “How are you feeling today?” It can also be helpful to have patients rate their stated mood on a scale of 1–10. WARDS QUESTION Q: What is a flat affect? A: A patient who remains expressionless and monotone even when discussing extremely sad or happy moments in their life. This is analogous to performing a physical exam in other areas of medicine. It is the nuts and bolts of the psychiatric exam. It should describe the patient in as much detail as possible. The mental status exam assesses the following: n Judgment/Impulse control The mental status exam tells only about the mental status at that moment; it can change every hour or every day, etc. n Appearance: Gender, age (looks older/younger than stated age), type of clothing, hygiene (including smelling of alcohol, urine, feces), posture, grooming, physical abnormalities, tattoos, body piercings. Take specific notice of the following, which may be clues for possible diagnoses: • Pupil size: Drug intoxication/withdrawal. • Bruises in hidden areas: ↑ suspicion for abuse. • Needle marks/tracks: Drug use. • Eroding of tooth enamel: Eating disorders (from vomiting). • Superficial cuts on arms: Self-harm. n Behavior: Attitude (cooperative, seductive, flattering, charming, eager to please, entitled, controlling, uncooperative, hostile, guarded, critical, antagonistic, childish), positioning (sitting, standing), mannerisms, tics, eye contact, activity level, psychomotor retardation/activation, akathisia, automatisms, catatonia, choreoathetoid movements, compulsions, dystonias, tremor. Speech Rate (pressured, slowed, regular), rhythm (i.e., prosody), articulation (dysarthria, stuttering), accent/dialect, volume/modulation (loudness or softness), tone, long or short latency of speech, quantity of speech (hyperverbal, paucity of speech). Mood Mood is the emotion that the patient tells you they feel, often in quotations. Affect Affect is an assessment of how the patient’s mood appears to the examiner, including the amount and range of emotional expression. It is described with the following dimensions: n Type of affect: Euthymic, euphoric, neutral, dysphoric. n Range describes the depth and range of the feelings shown. Parameters: flat (none)—blunted (shallow)—constricted (limited)—full (average)—intense (more than normal). n Motility describes how quickly a person appears to shift emotional states. Parameters: sluggish—supple—labile.

n Appropriateness to content describes whether the affect is congruent with the subject of conversation or stated mood. Parameters: appropriate—not appropriate. Thought Process The patient’s form of thinking—how they use language and put ideas together. It describes whether the patient’s thoughts are logical, meaningful, and goal directed. It does not comment on what the patient thinks, only how the patient expresses their thoughts. n Logical/Linear/Goal-directed: Answers to questions and conversation clear and follows a logical sequence. n Circumstantiality is when the point of the conversation is eventually reached but with overinclusion of trivial or irrelevant details. Examples of thought disorders include: n Tangentiality: Can follow conversation but point never reached or question never answered. n Loosening of associations: No logical

connection from one thought to another. n Flight of ideas: Thoughts change abruptly from one idea to another, often based on understandable associations or distracting stimuli; usually accompanied by rapid/pressured speech. n Neologisms: Made-up words. n Word salad: Incoherent collection of words. n Clang associations: Word connections due to phonetics rather than actual meaning. “My car is red. I’ve been in bed. It hurts my head.” n Thought blocking: Abrupt cessation of communication before the idea is finished. Thought Content Describes the types of ideas expressed by the patient. Examples of disorders: n Poverty of thought versus overabundance: Too few versus too many ideas expressed. n Delusions: Fixed, false beliefs that are not shared by the person’s culture and remain despite evidence to the contrary. Delusions are classified as bizarre (impossible to be true) or nonbizarre (at least possible). n Suicidal and homicidal ideation: Ask if the patient feels like harming themself or others. Identify if the plan is well formulated. Ask if the patient has an intent (i.e., if released right now, would they kill themself or harm others?). Ask if the patient has means to kill themself (firearms in the house/ multiple prescription bottles). n Phobias: Persistent, irrational fears. n Obsessions: Repetitive, intrusive thoughts. Perceptual Disturbances n Hallucinations: Sensory perceptions that occur in the absence of an actual stimulus. • Describe the sensory modality: Auditory (most common), visual, gustatory, olfactory, or tactile. • Describe the details (e.g., auditory hallucinations may be ringing, humming, whispers, or voices speaking clear words). Command auditory hallucinations are voices that instruct the patient to do something. EXAMINATION AND DIAGNOSIS KEY FACT An example of inappropriate affect is a patient’s laughing when being told they have a serious illness. WARDS TIP A patient who is laughing one second and crying the next has a labile affect. KEY FACT Examples of delusions: • Grandeur—Belief that one has special powers or is someone important (Jesus, President). • Paranoid—Belief that one is being persecuted. • Reference—Belief that some event is uniquely related to patient (e.g., a TV show - character is sending messages to patient). • Thought broadcasting—Belief that one’s thoughts can be heard by others. • Religious—Conventional beliefs exaggerated (e.g., God wants me to be the Messiah). • Somatic—False belief concerning body image (e.g., I have cancer). WARDS TIP The following question can help screen for obsessions: Do you think and/or worry about checking, cleaning, or counting on a repetitive basis?

 WARDS QUESTION Q: What type of hallucinations are an important risk factor for suicide or homicide? A: Command hallucinations (auditory hallucinations that instruct a patient to harm themselves or others). Cognition n Orientation: To person, place, and time. n Calculation: Ability to add/subtract. n Memory: WARDS TIP Alcoholic hallucinosis refers to hallucinations (usually auditory, although visual and tactile may occur) that occur either during or after a period of heavy alcohol consumption. Patients usually are aware that these hallucinations are not real. In contrast to DTs, there is no clouding of sensorium and vital signs are normal. KEY FACT You can roughly assess a patient’s intellectual functioning by utilizing the proverb interpretation and vocabulary strategies. Proverb interpretation is helpful in assessing whether a patient has difficulty with abstraction. Being able to define a particular vocabulary word correctly and appropriately use it in a sentence reflects a person’s intellectual capacity. • Ask if the hallucination is experienced only while falling asleep (hypnagogic hallucination) or upon awakening (hypnopompic hallucination). n Illusions: Inaccurate perception of existing sensory stimuli (e.g., wall appears as if it’s moving). n Derealization/Depersonalization: The experience of feeling detached from one’s surroundings/mental processes. n Consciousness: Patient’s level of awareness; possible range includes: alert— drowsy—lethargic—stuporous—comatose. • Immediate (registration)—Dependent on attention/concentration and can be tested by asking a patient to

repeat several digits or words. • Recent (short-term memory)—Events within the past few minutes, hours, or days. • Remote memory (long-term memory). n Fund of knowledge: Level of knowledge in the context of the patient's culture and education (e.g., Who is the president? Who was Picasso?). n Attention/Concentration: Ability to subtract serial 7s from 100 or to spell "world" backward. n Reading/Writing: Simple sentences (must make sure the patient is literate first). n Abstract concepts: Ability to explain similarities between objects and understand the meaning of simple proverbs. Insight Insight is the patient's level of awareness and understanding of their problem. Problems with insight include complete denial of illness or blaming it on something else. Insight can be described as full, partial/limited, or minimal. Judgment Judgment is the patient's ability to understand the outcome of their actions and use this awareness in decision making; it is best determined from information from the HPI and recent behavior (e.g., how a patient was brought to treatment or medication compliance). Judgment can be described as excellent, good, fair, or poor. Mrs. W is a 52-year-old female who arrives at the emergency room reporting that her deceased husband of 25 years told her that he would be waiting for her there. To meet him, she drove nonstop for 22 hours from a nearby state. She claims that her husband is a famous preacher and that she, too, has a mission from God. Although she does not specify the details of her mission, she says that she was given the ability to stop time until her mission is completed. She reports experiencing high levels of energy despite not sleeping for 22 hours. She also reports that she has a history of psychiatric hospitalizations but refuses to provide further information.

While obtaining her history you perform a mental status exam. Her appearance is that of a woman who looks older than her stated age. She is obese and unkempt. There is no evidence of tattoos or piercings. She has tousled hair and is dressed in a mismatched flowered skirt and a red T-shirt. Upon her arrival at the emergency room, her behavior is demanding, as she insists that you let her husband know that she has arrived. She then becomes irate and proceeds to yell, banging her head against the wall. She screams, "Stop hiding him from me!" She is uncooperative with redirection and is guarded during the remainder of the interview. Her eye contact is poor as she is looking around the room. Her psychomotor activity is agitated. Her speech is loud and pressured, with a foreign accent. She reports that her mood is "angry," and her affect as observed during the interview is labile and irritable. Her thought process includes flight of ideas. Her thought content is significant for delusions of grandeur and thought broadcasting, as evidenced by her refusing to answer most questions claiming that you are able to know what she is thinking. She denies suicidal or homicidal ideation. She expresses disturbances in perception as she admits to frequent auditory hallucinations without commands. She is uncooperative with formal cognitive testing, but you notice that she is oriented to place and person. However, she erroneously states that it is 2005. Her attention and concentration are notably impaired, as she appears distracted and frequently needs questions repeated. Her insight, judgment, and impulse control are determined to be poor. You decide to admit Mrs. W to the inpatient psychiatric unit in order to allow for comprehensive diagnostic evaluation, the opportunity to obtain collateral information from her prior hospitalizations, safety monitoring, medical workup for possible reversible causes of her symptoms, and psychopharmacological treatment. BEDSIDE COGNITIVE TESTING The Montreal Cognitive Assessment (MoCA) The MoCA is a simple, brief test used to assess gross cognitive functioning. The test and its instructions are available online (Figure 2-2). The areas tested include: n Orientation (to person, place, and time). • Memory (immediate—repeating five words; and recent—recalling the words 5 minutes later). • Attention (serial 7s, tapping hand with certain letters, repeating digits). • Language (naming, repetition, fluency). • Abstraction (e.g., saying how a "train" and "bicycle" are

alike). • Visuospatial ability/executive functioning (trail making task, cube copying, clock drawing). The Mini-Mental State Examination (MMSE) The MMSE is another test of cognition that can be performed in a few minutes at the bedside. Unlike the MoCA, the MMSE is copyright protected. EXAMINATION AND DIAGNOSIS WARDS TIP To test ability to abstract, ask:

1. Similarities: How are an apple and orange alike? (Normal answer: “They are fruits.” Concrete answer: “They are round.”)
2. Proverb testing: What is meant by the phrase, “You can’t judge a book by its cover?” (Normal answer: “You can’t judge people just by how they look.” Concrete answer: “Books have different covers.”) KEY FACT A prior history of violence is the most important predictor of future violence.

16 EXAMINATION AND DIAGNOSIS Sample Write-Up FIGURE 2-2. Montreal Cognitive Assessment Test (MoCA). Copyright © Z. Nasreddine MD. Reproduced with permission. Copies are available at www.mocatest.org. CHIEF COMPLAINT: “I’m in despair and hopeless” HISTORY OF PRESENT ILLNESS: A 58 year-old domiciled, recently unemployed, single female with a past psychiatric history of depression and no past medical history who presented to the emergency room for depression and suicidal ideation with a plan to jump in front of a train. The patient explained that she was working as an Licensed Practical Nurse (LPN) for a nursing home when the coronavirus pandemic began. She currently lives with her mother and brother. Her mother is elderly with chronic medical conditions, so they serve as her caretakers. When patients and staff at the nursing home began to test positive for COVID, the patient’s brother urged her to quit, given her elevated risk of infection and potential spread to the rest of her family.

She therefore quit her job and has been staying at home with her mother in quarantine for 4 months. For the past 2 months, she has noticed a decline in her mood. She describes feeling “in despair and hopeless…I feel so useless now.” She has also been experiencing hypersomnia with worsening fatigue, poor appetite, anhedonia, anergia, and difficulty concentrating. She expressed that for the past 2 weeks she has had suicidal ideation with a plan to jump in front of the train near her home. She denies preparatory behaviors or prior suicide attempts. She denies self-harm behaviors. She realized she needed help now because the suicidal thoughts were becoming more persistent. She notes that her family is what has prevented her from acting on these thoughts. She denies any auditory/visual hallucinations, clustered manic symptoms, or homicidal ideation. She denies any illicit drug or alcohol use. Of note, for the past week, she has been taking a friend’s sertraline to help with her mood. Patient was amenable to inpatient psychiatric admission. She was agreeable to starting sertraline for her depression. PAST PSYCHIATRIC HISTORY: Diagnoses: Depression Prior Hospitalizations: One time at age 38 for similar symptoms of depression. She was treated with sertraline 50 mg with significant improvement in her symptoms. She continued medications and outpatient therapy for 1 year, but she discontinued both because her depressive symptoms resolved. Prior Self-Injury: No history of suicide attempts or self-harm SUBSTANCE USE:

- Tobacco: Smokes 1/2 pack per day
- Alcohol: None
- Illicits: None
- Rehabilitation: Denies PAST MEDICAL HISTORY: None. No history of seizures or head trauma. MEDICATIONS: Sertraline 50 mg daily ALLERGIES: No known drug allergies FAMILY

HISTORY: Mother with depression but not treated. No history of suicide attempts. SOCIAL HISTORY

- Lives with brother and mother in apartment
- No history of physical or sexual abuse.
- Development: Met all milestones on time
- Employment: Was working as LPN at a nursing home, currently unemployed
- Education: 2 years of college
- Relationship: Single, never married, no children
- Legal: No legal problems EXAMINATION AND DIAGNOSIS

18 EXAMINATION AND DIAGNOSIS MENTAL STATUS EXAM

- Appearance: Medium-built female, dressed in hospital gown, good grooming and hygiene, appears consistent with stated age
- Behavior: Sitting comfortably, cooperative during interview, attentive, maintains appropriate eye contact; some psychomotor retardation, no abnormal movements/tics
- Speech: Increased speech latency, low tone, normal prosody
- Mood: “Hopeless”
- Affect: Dysphoric, constricted, congruent with stated mood, non-labile
- Thought Process: Linear, logical, goal-directed
- Thought Content: +Suicidal ideation with plan to jump in front of train, denies homicidal ideation, paranoia, or delusions
- Perceptions: Denies auditory or visual hallucinations and does not appear to be responding to abnormal internal stimuli
- Cognition: Alert and oriented to person, place, and time; memory intact to recent/remote events, good attention (able to do serial 7s)
- Insight: Good—realizes she is having similar symptoms to prior episode of depression related to job loss and isolation.
- Judgement: Fair—brought herself in when she was feeling more suicidal but taking friend’s sertraline. ASSESSMENT: Patient is a 58 year-old, domiciled, recently unemployed, single female with a past psychiatric history of depression and no past medical history who presented to the emergency room for depression and suicidal ideation with a plan to jump in front of a train. Biologically, she has a first-degree parent (mother) with a history of depression. She denies illicit drug use or alcohol use, therefore not a substance-induced mood disorder. She has a history of depression, and currently has major neurovegetative signs and symptoms consistent with another major depressive episode. She has suicidal ideation with a plan to jump in front of a train and is therefore at high acute risk of harm to self. Psychosocially, her recent unemployment and home quarantine due to the coronavirus was the catalyst for her current mood disturbance. She requires inpatient hospitalization for acute safety/stabilization as she poses a significant risk of harm to herself. Principal DSM-5 diagnosis: Major depressive disorder, recurrent, severe PLAN:
- Admit to inpatient psychiatry
- Vitals: Per ward routine
- Labs: Chemistry panel, complete blood count, urine toxicology screen, blood alcohol level, thyroid panel
- Diet: General

- Activity: Up ad lib

# Depression

- Start sertraline 50 mg daily given prior benefit and tolerability

# Tobacco Use

- Offer nicotine replacement (e.g., nicotine patch/gum) #Social/disposition: Consider family meeting, refer to outpatient medication management, consider psychotherapy

Interviewing Skills GENERAL APPROACHES TO TYPES OF PATIENTS Violent Patient Do not interview a potentially violent patient alone. Inform staff of your whereabouts. Know if there are accessible panic buttons. To assess violence or homicidality, one can simply ask, “Do you feel like you want to hurt someone or that you might hurt someone?” If the patient expresses imminent threats against specific friends, family, or others, the doctor must notify potential victims and/or protection agencies (Tarasoff Rule). Delusional Patient Although you should not directly challenge a delusion or insist that it is untrue, you should not imply you believe it either; you should simply acknowledge that you understand that the patient believes the delusion is true. Depressed Patient A depressed patient may be skeptical that they can be helped. It is important to offer reassurance that they can improve with appropriate therapy. Inquiring about suicidal thoughts is crucial; a feeling of hopelessness, substance use, and/or a history of prior suicide attempts reveal an ↑ risk for suicide. If the patient is actively planning or contemplating suicide, they should be hospitalized or otherwise protected. Diagnosis and Classification DIAGNOSIS AS PER DSM-5 The American Psychiatric Association (APA) uses a criterion-based system for diagnoses. Criteria and codes for each diagnosis are outlined in the DSM-5. Diagnostic Testing INTELLIGENCE TESTS Aspects of intelligence include memory, logical reasoning, ability to assimilate factual knowledge, and understanding of abstract concepts. Intelligence Quotient (IQ) IQ is a test of intelligence with a mean of 100 and a standard deviation of 15. These scores are adjusted for age. An IQ of 100 signifies that mental age equals chronological age and corresponds to the 50th percentile in intellectual ability for the general population. Intelligence tests assess cognitive function by evaluating comprehension, fund of knowledge, math skills, vocabulary, picture assembly, and other verbal and performance skills. Two common tests are: Wechsler Adult Intelligence Scale (WAIS): n Most common test for ages 16–90. n Assesses overall intellectual functioning. n Four index scores: Verbal comprehension, perceptual reasoning, working memory, processing speed. Wechsler Intelligence Scale for Children (WISC): Tests intellectual ability in patients ages 6–16. EXAMINATION AND DIAGNOSIS WARDS TIP In assessing suicidality, do not simply ask, “Do you want to hurt yourself?” because this does not directly address suicidality (they may plan on dying in a painless way). Ask directly about killing self or suicide. If contemplating suicide, ask the patient if they have a plan of how to do it and if they have intent; a detailed plan, intent, and the means to accomplish it suggest a serious threat. KEY FACT The Minnesota Multiphasic Personality Inventory (MMPI) is an

objective psychological test that is used to assess a person’s person ality and identify psychopathologies. The mean score for each scale is 50 and the standard deviation is 10. WARDS TIP IQ Chart Very superior: >130 Superior: 120–129 High average: 110–119 Average: 90–109 Low average: 80–89 Borderline: 70–79 Extremely low (intellectual disability): <70

20 EXAMINATION AND DIAGNOSIS n Most commonly used. Thematic Apperception Test (TAT) Rorschach Test n Interpretation of inkblots. OBJECTIVE PERSONALITY ASSESSMENT TESTS These tests are questions with standardized-answer format that are objectively scored. The following is an example: Minnesota Multiphasic Personality Inventory (MMPI-2) n Tests personality for different pathologies and behavioral patterns. PROJECTIVE (PERSONALITY) ASSESSMENT TESTS Projective tests have no structured-response format. The tests often ask for interpretation of ambiguous stimuli. Examples are: n Test taker creates stories based on pictures of people in various situations. n Used to evaluate motivations behind behaviors. n Used to identify thought disorders and defense mechanisms.