

THE PSYCHIATRIC INTERVIEW AND MENTAL STATUS EXAMINATION

The ideal psychiatric interview/write-up/presentation is one in which the presenter is able to convey clinically relevant information in a clear, concise, organized manner. A good presenter will leave a "picture" of the patient being presented in the other's mind after the presentation is completed, making it easier to formulate a problem list and differential diagnosis.

The following format is generally accepted, with mild alterations made per individual attending.

I. Identifying Information

Start the write-up/presentation with a clear statement about the patient which helps the listener/reader get a picture of the person. Example: 54 yo married white female who is 8 months pregnant.

II. Chief Complaint

This is the patient's chief complaint, and you should write down what the patient states is the reason for coming in to be evaluated. Do not use technical terminology unless the patient does, rather, put down exactly what the patient says, usually in quotations. Example: Patient's chief complaint is "I feel depressed;" patient's chief complaint is "I need a refill of medicine."

III. History of Present Illness

Write down an organized, chronological history of what brings the patient into the hospital now, including all significant symptomatology, precipitating factors, etc... If the patient is presenting to you with a six month history of depression which started when the patient's father died, start six months ago with the death of the father and report what has been going on since then, in chronological order, up until the current time of the interview. Include significant modifiers of the illness, including possible organic factors, drug, and alcohol abuse. List all pertinent positive and negative symptoms, which will help you to make an accurate DSM-IV (differential) diagnosis.

IV. Past Psychiatric History

Put all contact the patient has had with therapists (psychiatrists, psychologists, social workers, and counselors), inpatient units, and other outpatient experiences. Be sure to include prior rehabilitation programs. If the patient has been on psychotropic medications in the past, list these by date, how long the patient took each one, at what dose, and the effect the medication had on the patient. List any ECT the patient might have had. Also list prior suicide attempts and methods.

V. **Past Medical History**

List in this area any current medical problems the patient has, and then any past medical, surgical or obstetric problems the patient has had, in chronological order. List the hospitalizations. List all medications (including the doses) the patient is currently taking. List any allergies the patient has and what the specific reactions to the medications were.

VI. **Family History**

A genogram is often useful here for clarity. List all illnesses that patient's family has had, including medical, psychiatric, and substance abuse history. Write down any psychotropic medications which have been beneficial in family members. Include suicide attempts or completed suicide in family members. Include whether the family members are currently living or are dead. Include patient's parents, siblings, and children.

VII. **Social History/Developmental History**

List all substances the patient currently is taking; drugs, alcohol, cigarettes. List how much the patient uses of each, how often, for how many years and in what form (smoke, IV, etc...). Document when the last time used. List patient's educational history, work history, and what the patient currently does to support himself/herself. Are there any ongoing legal issues, felonies, warrants, etc... Ask who the patient currently lives with. Ask about the patient's marital status, sexual orientation, sexual activity, children, etc...

VIII. **Review of systems**

Put in this category any other information you might have received; i.e., the patient told you he is short of breath a lot, he has blurred vision. It is sometimes useful to ask a patient to tell you anything he considers important for you as the physician to know that you have not yet asked.

IX. **Mental Status Exam**

The mental status exam is extremely important. The best mental status exams allow the person listening to the presentation to develop a snapshot of the patient being presented.

Appearance: Start out the mental status exam by giving a verbal picture of the patient, what the patient is doing, wearing, and how the patient looks. For example: 16 yo BM wearing age appropriate dress of clean jeans, a t-shirt, and sneakers with the laces undone. He was sitting on the floor playing with a train set. He looked up and smiled when the interviewer approached.

16 yo BM O X 3 is a lot less descriptive!

After the initial description you have probably already taken care of the general appearance, alertness, hygiene and grooming part of the general description, but if not, include some

information here. Look for use of grooming that might be suggestive of a mood state or disorganization. Don't use diagnostic labels, just describe what you see.

Speech: volume, rate, idiosyncratic symbols or other odd speech, tone (include any accent or stuttering).

Motor activity: rate (agitated, retarded), purposefulness, adventitious (non-voluntary).

Mood: ask how they are feeling, usually put in quotes: "depressed," "sad," "great," ect....

Affect: observable emotion (euthymic, neutral, euphoric, dysphoric, flat) the range (full, constricted, blunted), whether it's appropriate to stated mood or content, lability.

Thought process: organization of a person's thoughts (logical/linear, circumstantial, tangential, flight of ideas, loose associations, or thought blocking).

Thought content: basic themes preoccupying the patient, suicidality, homicidality, paranoia, delusions, ideas of reference, obsessions, compulsions. If there is suicidal or homicidal ideation, is there a plan, intent?

Perceptual disturbances: hallucinations (auditory, visual, olfactory, tactile), illusions, derealization/depersonalization.

Cognitive: level of alertness and orientation. May want to perform full Folstein MMSE if concerned about dementia or delirium.

Insight: into level of illness and/or need for treatment/hospitalization.

Judgment/Impulse control: best determined by history or patterns of behavior and current attitude.

IX. **Physical Exam**

Many medical diseases masquerade as psychiatric, and vice versa (pancreatic CA, hypothyroidism, brain metastases). Do a thorough PE including full neurological exam and document. This usually does not include a breast, pelvic, rectal, or genital exam on inpatients.

X. **Problem List**

XI. **Differential Diagnosis**

MULTI AXIAL ASSESSMENT

Axis I Clinical Disorders
 Other conditions that may be a focus of clinical attention

Axis II Personality Disorders/Traits

Mental Retardation

Axis III General Medical Conditions influencing diagnosis, treatment, or prognosis of Axis I or II disorders.

Axis IV Psychosocial and Environmental Problems
e.g., problems with primary support group, problems related to the social environment, educational problems, occupational problems, housing problems, economic problems, problems with access to health care services, problems related to interaction with the legal system/crime, other.

Axis V Global Assessment of Functioning
This scale is for reporting the clinician's judgment of the individual's overall level of functioning. This information is useful in planning treatment and measuring its impact and in predicting outcome. The scale ranges from "0" (inadequate information) to "100" (no symptoms and superior functioning in a wide range of activities).

XII PLAN

Include biological (medications, labs, studies), psychological (individual therapy, group therapy, psychological testing), and social (housing, access to care, social services) interventions.

SAMPLE MEDICAL STUDENT WRITE-UP

ID: Patient is a 24 year old SBF who lives in a shelter with her six children and is unemployed.

Source: Patient is a fairly good historian, UIH records, D. Smith, patient's outpatient psychiatrist, and DCFS.

Chief

Complaint: "I wish I wasn't here."

HPI: Patient, who reports that she has "felt depressed all [her] life," says she began wishing "not to be here" one day PTA, after seeing her mother for the first time in a year, and arguing with her.

Patient describes her mother as a drug addict and describes angry feelings related to the neglect she suffered as a child. Patient reports being "raped" by a baby-sitter at the age of 9 and 12 and feels angry with her mother for not having protected her from that experience and for not having sought treatment for her afterward.

At the age of 16, while pregnant, patient moved in with the father of her child and his parents, where she remained for 5-6 years. She and the child's father, who is the father of 5 of patient's 6 children, later moved into an apartment together. Patient reports that she had left her children in the care of her boyfriend and his father one day and came home to find that her 3 year old daughter had been badly burned while in their care. (This child is the only child who was not fathered by patient's boyfriend; patient became pregnant by another man while her boyfriend was in the penitentiary.) The child was taken to University Hospital for treatment, and staff there notified DCFS. As a consequence, patient was told she could not leave her children in that situation again. This case is still pending before DCFS, but patient states that the file will be closed soon.

Since that time, patient had an apartment by herself. About 3 months ago, however, patient and her 6 children (the youngest of whom is 6 months old) were evicted for non-payment of rent. Since then, patient and her children have lived in a shelter, and patient has been trying to find a place to go and feeling badly about the prospects. Patient is worried about the effect of the public housing environment on her children. After fighting with her mother one day PTA, patient felt she just didn't want to suffer any more. She also says she thinks of killing herself to make her mother sorry for the neglectful way she treated her. Then she thinks of her

children, however, and realizes they would suffer too, and doesn't think so much of killing herself. She has no active plan to commit suicide.

Patient reports feeling depressed and irritable, frequent crying spells, midnight awakenings with difficulty returning to sleep (averaging 2-4 hours of sleep at night, but sleeping during the day), low self-esteem, low energy and anorexia for several days. (She denies weight loss and also complains of GI pain after eating). She also denies helplessness, hopelessness, and decreased concentration, feelings of guilt, worthlessness or shame. Patient also describes hearing male voices telling her what she should do and commenting on her activities, and "seeing" the baby-sitter who raped her standing near her. Patient reports frequent nightmares about the baby-sitter. She reports hypervigilance, hyperstartle response, remembering the rape even though she doesn't want to, and trying to avoid reminders of these events.

Past Psychiatric

History: This is the 3rd hospital admission for this patient

4/21/05 to
5/17/05

Patient admitted after swallowing 10 Tylenol, with major depressive episode, PTSD. Patient took pills at girlfriend's house. Thought girlfriend was outside, but GF walked in on her in the act of swallowing pills. Patient was pregnant.

6/22/04 to
7/1/04

Patient admitted for worsening signs of depression. Dx: major depression, PTSD.

6/12/03 to
6/21/03

Patient admitted after swallowing 28 Tylenol and drinking ETOH. Grandmother had been recently diagnosed with cancer at the time and boyfriend had told her he was seeing another woman. Patient was pregnant at the time.

Past Psych

Meds:

Effexor – discontinued due to nausea.

Prozac - good therapeutic effect documented with no side effects.

Discontinued as "it stopped working."

Zyprexa - improved AH

Pamelor - Mood improved. Discontinued for unknown reason.

Past Psych

Treatment: D. Smith, seen once a month
Dr. Jones, Hospital Y - patient was to F/U - never seen after discharge
No other psychiatric treatment

Past Suicide

Attempts: Twice (see past hospitalizations)

PMHx: Asthma - last attack in 11/05 - attacks 2 to 3 times per month. Never intubated.
HTN - "always" - but BP nml and no HTN meds.
H/O - Gallstones - RX → ↓Sx. Type of Rx unknown.
Ulcer - Dx at University Hospital - 1/96 - No Tx so far.

PSHx: None

PObHx: G₇P₆ NSVD x 6 1999, 2000, 2001, 2003, 2004, 2005.
SpAb x 1 6/94

PGynHx: STD: Syphilis - RX @ Community Clinic, 2003
HIV test (-) @ Community Clinic, 2003
LMP: 12/04
Birth control: Depoprovera (last IM dose 2/27/06)
Last Papsmear: Community Clinic 2/27/06
Last Pelvic Exam: Community Clinic 2/27/06
Never had abnl pap smear

Meds: Zolof 200 mg po qhs,
Ventolin inhaler prn SOB
Risperidone 4 mg po qhs
Ambien 20 mg po qhs prn insomnia

All: PCN ⇒ rash
Codeine ⇒ rash

FAMILY HISTORY

Psych: Grandmother - depression, never hospitalized
Mother - cocaine addiction
No suicide attempts in family

Med: Grandmother - colostomy, "kidney problem" (DM - patient denies)
Patient has one brother who is healthy. No 1/2 - sibs.
Children are all healthy.

Social/Development

- History:** Lives in shelter - see HPI
Monogamous (mostly) relationship for 8 years
Unemployed - never employed
Education - 8th grade. Patient taken out of school to care for younger brother.
Patient lived with mother (addict) until age 16. Financially supported by grandmother. At 16, moved in with boyfriend and family. History of physical abuse by stepfather.
Tob - denies
ETOH - denies except once, when patient attempted suicide
Illicit Drugs - denies
Patient receives public aid - approximately \$450 per month.
No ongoing legal problems.
- ROS:** Patient complains that her stomach hurts all the time. She feels worse after eating, and sometimes has nausea and/or vomiting after eating.
Denies coffee - ground hematemesis. Once, her vomit was tinged with blood. She has "internal hemorrhoids" and has had BRBPR as a result. 2 days PTA, she had dark, "tarry" stools. Mylanta, Maalox and Tums do not help her GI pain, but lying on her stomach does help.
She was seen at outside hospital on 3/18/96 for this. They tried to aspirate her stomach via an NG tube, but she refused to cooperate.
- MSE:** **Appearance** - patient is overweight female, dressed in hospital gowns, hair neatly groomed with good hygiene.
Behavior - cooperative, with poor eye contact. Psychomotor retardation.
Speech - ↓ rate and volume. No dysarthria. Monotone.
Mood - "depressed."
Affect - dysphoric, tearful, constricted, but appropriate, and nonlabile.
TP - linear, without looseness of association or flight of ideas.
TC - ⊕ SI with no plan currently. No homicidal ideation.
No ideas of reference. No paranoia. No delusions.
Perceptual disturbances - ⊕AH/⊕VH.
Cognitive - Grossly intact. MMSE 30/30. Alert and oriented times 3.
Insight - poor-patient does not identify reasons for depression except for the concrete.
Judgment - fair - patient knew to come to hospital to prevent suicide.
- P.E.:** Patient is an obese BF who appears her stated age, in no apparent distress.
- VS. BP 119/79 HR 91 R 24 T (98.6°)

HEENT: EOMI, PERRLA, NCAT. Mucous membranes moist, no lesions in mouth/oropharynx. Fundi/tympanic membranes not visualized. Skin - warm, dry. No marks, track marks. Tattoos on left forearm
 Neck - no JVD, Ø thyromegaly, Ø LAD
 Back - no CVAT

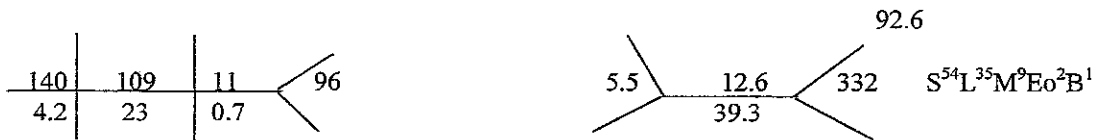
Lungs - CTA bilaterally ⊖ rales/wheezes/crackles
 CV - RRR, without murmurs or rubs
 Breasts - deferred
 Abd. - BS nl, obese. Direct tenderness RUQ, LUQ
 No rebound tenderness. No organomegaly.
 Stretch marks.
 Ext. - No clubbing, cyanosis, or edema. Peripheral pulses present.
 Neuro – CN I not tested
 CN II - XII intact
 Romberg - no drift
 Gait - nl tandem
 nl toes
 nl heels

Sensory - proprioception - absent left L foot, right LE + bilat. UE intact
 vibratory - absent L foot, right LE + bilat. UE intact
 sharp/dull/differentiation - absent L foot, RLE + bilat. UE intact
 Strength – 5/5 bilat
 DTRs – 2+ throughout. No Babinski

Cerebellar – nl heel – to – shin
 nl finger – to – nose
 nl rapid alternating movements

Rectal and Genital - deferred

Labs:



T3U 26.0
 T3 0.9
 T4 6.8

Amylase 240 (25 - 125)
 Urine toxicity screen - negative
 HCG - negative
 UA - RBC 7/HPF
 WBC 11/HPF
 Bacteria Few
 Sq.Epi 15/HPF
 all other WNL

Albumin 3.3 g/dl (stands for grams per deciliter) (3.6 - 5.0 = nl)

AlkØ	38 U/L (40 - 125 = nl)
ALT	13 U/L
AST	12 U/L
GGT	8 U/L
TBili	0.3 ug/dl
Dbili	0.0 ug/dl
Total Pr	7.4 g/dl

Problem List

1. Suicidal ideation with no plan
2. Depressed mood
3. Intrusive thoughts of rape
4. Hypervigilance, hyperstartle
5. AH/VH
6. Psychosocial stressors - living in shelter, 6 children, poverty, mother's addiction, DCFS case pending
7. Asthma
8. GI pain/ulcer?
9. ↓ sensation left foot
10. h/o STD ⇒ ↑ risk of HIV
11. Obesity

Differential Diagnosis

1. **Post Traumatic Stress Disorder** - Patient meets all of the criteria for this disorder: reexperiencing the traumatic event, three arousal criteria (difficulty staying asleep, ↑ startle response, hypervigilance), and three avoidance criteria (avoiding trauma-associated thoughts, restricted range of affect, avoiding trauma-related people). It would also account for patient's description of her VH, although not her AH.
2. **Major Depressive Episode with Psychotic Features** - patient may meet the criteria for a MDE: depressed irritable mood, frequent crying spells, ↓ self-esteem, ↓ energy, midnight awakenings with difficulty returning to sleep, and anorexia. These last two are equivocal because patient reports being awakened by/kept awake by her six-month old infant. Also, although patient complains of anorexia, she also complains of intense GI pain with eating. Nevertheless, this Dx would explain patient's ego-dystonic AH (voices telling her what she ought to do) which she experiences as critical.
3. **Dysthymic D/O** - if patient does not meet the criteria for a MDE, she meets both the duration criteria (>2 years) and the mood criteria for dysthymic D/O. Also, no manic Sx or h/o manic Sx are elicited. Patient may simultaneously meet the criteria of dysthymic D/O and a MDE, leading to a Dx of "double depression."

4. **Adjustment D/O** - Patient has had several stressful events in her life recently - the birth of a child, eviction from her apartment, seeing her mother after one year. Patient's depressive symptoms could be a consequence of these stressors, leading to a Dx of adjustment D/O with depressed mood. This diagnosis assumes, however, that these symptoms are transient. Given her h/o depression ("all my life"), this seems unlikely.

Formulation

Patient's current symptoms can best be described as a major depressive episode superimposed on dysthymia with concurrent post-traumatic stress disorder or MDE with PTSD. Her status is unchanged since her last MDE in 2003; she had no follow-up psychotherapy or other treatment. Approximately three months ago, additional psychosocial stressors of being evicted from an apartment with an infant and five older children caused her mood to further deteriorate and led her to seek medication. Her recent fight with her mother evoked neglect issues from her past, compounding the burdens of the DCFS case pending against her for neglect of her own children. Overwhelmed, patient sought refuge in mental health care. She could best be helped by helping her recognize the connection between feeling overwhelmed/depressed/suicidal and seeking medical attention (i.e., being made to see that she need not be in crisis before asking for/receiving help). At that point, the real, tangible problems in her life (homelessness, poverty) could be addressed systematically, rather than being allowed to overwhelm monolithically. Finally, while the patient has numerous medical problems, none of these contributes significantly to her current mental condition. Given that she has had good responses to medication in the past, she may be helped by them now. Possibilities include an antipsychotic for AH/VH and a mood-stabilizer (preferably not a TCA, given h/o O.D. by pills).

Diagnoses

Axis I – Major Depressive Disorder, recurrent, with psychotic features
Post – Traumatic Stress Disorder
Dysthymic Disorder
Axis II – Deferred, r/o Borderline traits
Axis III – Obesity, asthma, r/o PUD
Axis IV – Homelessness, financial problems, poor psychosocial support
Axis V – Current GAF - 35

Plan

1. SI - admit to 8E, Q 30' checks for SI.
2. Depressed mood - continue sertraline 200 mg po qhs.
3. Sx of AH/VH - continue risperidone 4 mg po qhs.

4. Psychosocial stresses - supportive interactions, group tx. Social worker to work with patient to apply for SSI, work on housing issues.
5. Asthma - albuterol inhaler prn SOB.
6. GI pain/ulcer - GI consult.
7. ↓ sensation left foot - neuro consult.
8. H/O STD/HIV risk - pregnancy + STD prevention counseling.
9. Obesity - nutritional counseling.

Signature of Student