

Mental Status Examination

- Appearance, attitude and motor activity** – dress, grooming, signs of illness and behavior
- Mood and affect** - range, lability appropriateness
- Speech** – quality
- Thought** – *Content*
Delusion, suicidal & homicidal ideations, obsessions
- Thought** – *Form*
Circumstantiality, tangentiality, loosening of associations, flight of ideas, derealization, depersonalization, dissociative events, concreteness, grandiosity
- Perception** - Hallucinations and illusions
- Complete mental state examination**
 - Alertness
 - Orientation to time, place, and person
 - Concentration
 - Recent and remote memory
 - Language (e.g., naming objects, repeating phrases, performance of commands)
 - Calculations
 - Construction
 - Insight and judgment

Differentiation of Delirium, Dementia & Depression

	Delirium	Dementia	Depression
Consciousness	Waxing and waning	Normal	Normal
Hallucinations & illusions	Frequent	Uncommon in mild - moderate dementia	Rare (unless psychosis is present)
Onset	Abrupt	Insidious	Discrete
Memory complaints	Absent	Hides or denies	Present
Responses	Could be incoherent	Near-miss answers	"I do not know"

Major causes of delirium:

I WATCH DEATH

Infection
Withdrawl (from benzos)
Acute metabolic
Trauma
CNS pathology
Hypoxia
Deficiencies (vitamins)
Endocrine
Acute vascular accident/MI
Toxins/drugs
Heavy metals

Symptoms of depression:

SIG-E-CAPS

Sleep (hypersomnia or insomnia)
Interest (loss of interest in activities pt once enjoyed)
Guilt (inappropriate guilt, feelings of worthlessness)
Energy (decreased)
Concentration (decreased)
Appetite (increased or decreased)
Psychomotor agitation/retardation
Suicidal ideation



Management of Overdose: complications, antidotes, lethal doses

Acetaminophen	Hepatotoxicity: peaks at 72–96 hrs. Complete recovery generally day 4, but injury worse for alcoholics. Mortality: 1%–2%. Antidote/treatment: <i>Acetylcysteine</i> . Potential lethal dose: <i>140 mg/kg</i>
Alcohol	Respiratory depression. Antidote/treatment: <i>None</i> Potential lethal dose: <i>350–700 mg (serum)</i>
Amphetamines	Seizures; avoid neuroleptics. Antidote/treatment: <i>None</i> Potential lethal dose: <i>20–25 mg/kg</i>
Barbiturates: 1. Short-acting 2. Long-acting	Respiratory depression. Antidote/treatment: <i>None</i> . 1. Short-acting: Potential lethal dose: <i>>3 g</i> 2. Long-acting: Potential lethal dose: <i>>6 g</i>
Benzodiazepine	Sedation, respiratory depression, hypotension, coma Antidote/treatment: <i>Flumazenil reverses effects (but it may induce W/D in the dependent)</i>
Carbon monoxide	Headaches, dizziness, weakness, N/V, diminished visual acuity, tachycardia, tachypnea, ataxia, seizures. Possible hemorrhages (cherry red spots on the skin), metabolic acidosis, coma, and death. Treatment: <i>Hyperbaric oxygen</i>
Cocaine	Peak toxicity 60–90 min. after use; systemic sympathomimesis & seizures, acidosis. Later cardiopulmonary depression, possible pulmonary edema. Treatment of acidosis, seizures, & HTN is imperative. Antidote/treatment: <i>Narcan (empirically)</i>
Non-benzo hypnotics	Delirium, extrapyramidal syndrome. Potential lethal dose: <i>Varies with tolerance</i>
Hydrocarbons	GI, reparatory, and CNS compromise Antidote/treatment: <i>None</i>
Opioids	Miosis, resp. depression, obtundation, pulmonary edema, delirium, death. Antidote/treatment: <i>Naloxone, nalmefene helpful</i> . Potential lethal dose: <i>Varies with tolerance</i>
Phencyclidine / ketamine	HTN, nystagmus, rhabdomyolysis Antidote/treatment: <i>None. Don't attempt forced diuresis in O/D w/ suspected rhabdomyolysis.</i>
Phenothiazines	Anticholinergism, extrapyramidal side effects, cardiac effects Antidote/treatment: <i>monitor for 48 hours for cardiac arrhythmia. Lidocaine cardiac arrhythmia, norepinephrine for hypotension, sodium bicarbonate for metabolic acidosis, and Dilantin for seizures.</i> Potential lethal dose: <i>150 mg/kg</i>
Salicylates	CNS, acidosis Antidote/treatment: <i>None</i> Potential lethal dose: <i>500 mg/kg</i>
Tricyclics	Cardiac effects, hypotension, anticholinergism Antidote/treatment: <i>None</i> Potential lethal dose: <i>35 mg/kg</i>
Hallucinogens	Ring-substituted amphetamines; LSD / mescaline may lead to rhabdomyolysis, hyperthermia, hyponatremia Antidote/treatment: <i>Reduce temperature, administer dantrolene</i>
Inhalants	Cardiotoxicity, arrhythmias Antidote/treatment: <i>Cardiac monitoring</i>



THE PSYCHIATRIC INTERVIEW

**allow the patient to speak freely and encourage with open-ended questions*

1. Identifying Information: age, sex/gender, marital status, religion, employment, living condition
2. CC: Quote the patient.
3. HPI: *OPQRST*
 - a. Onset: sudden or insidious
 - b. Precipitants: events, drugs or alcohol, etc.
 - c. Quality: character of the symptom(s)
 - d. Radiation: any associated symptoms
 - e. Severity: the impact on pt's life, daily functioning, family and friends
 - f. Timing: intermittent vs constant; what makes it better? Worse?
4. Past Psychiatric History
 - a. First psychiatric contact: what led to it?
 - b. Past hospitalizations: how many? For what? Any state hospitalizations?
 - c. Medication history
 - d. Current psychiatric care
 - e. Past suicide attempts: What led to it? What did you do? What stopped it?
 - f. Deliberate self harm: burning, cutting, purging
5. Substance Abuse History
 - a. Name them for the patient (EtOH, marijuana, heroin, cocaine)
 - b. Amount and Duration of use
 - c. Precipitants, Attitude toward use
 - d. History of withdrawal
 - e. Longest time sober?
 - f. Past treatments
6. Family History
 - a. Parents and siblings, and their ages
 - b. Relatives with mental illness: clarify (h/o alcoholism? Drug abuse? Criminality? Severe depression? Suicide attempts?)
 - c. Relevant medical history
7. Social History
 - a. Born and raised: what was your childhood like? What sort of problems? Who was in the house? Line up of kids?
 - b. Sexual and relationship history
 - c. Education (how far? where?)
 - d. Employment
 - e. Religious affiliation
 - f. Cultural background
 - g. Legal (h/o violence or arrests)
 - h. Abuse: Physical, Sexual, Emotional, Neglect? If yes, once or ongoing? help?
8. Mental Status Exam
9. Past Medical History
10. Medications
11. Allergies



THE PSYCHIATRIC INTERVIEW, continued

12. Psychiatric Review of Systems

a. Depressive:

- S: Have you had periods of feeling sad, despondent or hopeless?
- I: Have you noticed a change in your interest in things you normally enjoy?
- G: Have you been feeling down on yourself? Guilty about anything?
- E: Have you tended to feel more tired than usual? As if all your energy is drained?
- C: Have you had trouble concentrating? Making decisions?
- A: Have you had any changes in your appetite? Lost or gained weight?
- P: Have you felt restless or agitated? Have you been feeling slowed down?
- S: have you had trouble sleeping? (initial, middle, terminal)
- S: Have you ever felt that life isn't worth living? Thought about taking your own life?

b. Anxiety:

1. Have you ever experienced a sudden attack of panic or fear in which you felt extremely uncomfortable? Did you feel as if you were going to die or go crazy?
2. Ever been afraid of going outside, so that you tended to stay home all the time?

c. OCD

1. Are you ever bothered by persistent ideas that you can't get out of your head, such as being dirty or contaminated?
2. Is there anything you have to do over and over, such as washing your hands or checking the stove?

d. Mania:

DIGFAST (distractibility, insomnia, grandiosity, flight of ideas, activity, speech, thoughtlessness)

1. Have you ever felt extremely good or high, clearly different from your NL self?
2. Have you felt your thoughts are racing through your mind?
3. Did you need less sleep than usual to feel rested?
4. Have you done anything that caused trouble for you or your family/friends?

e. Psychosis

Delusions:

- Persecutory: have you felt that people are against you? Trying to harm you in any way?
- Grandiose: Do you have any special powers, talents or abilities?
- Thought broadcasting: Have you heard your own thoughts out loud, as if they were a voice outside your head? Have you felt that your thoughts were broadcast so that other people could hear them?

Hallucinations:

- Have you heard voices no one else could hear? When no one was around and you couldn't account for them? Seen things?

Emergency Room Psych

Presenting problem

- Observe behavior
- Data from collateral contacts
- Vital signs
- Indications of physical illness
- Current medications and allergies
- Medical and psychiatric histories

Evaluation

- Risk to self or others?
- Escape risk?
- Secondary to a medical condition?

Immediate nursing care measures

- Assess how long patient can wait for further evaluation
- Environment must be safe (e.g. remove potentially dangerous objects)
- Be sure to prevent an immediate medical emergency

Reference:

Allen MH (Editor): *Emergency Psychiatry* (Review of Psychiatry Series, Volume 21, Number 3; Oldham JM and Riba MB, series editors). Washington, DC, American Psychiatric Publishing, 2002.

Assessing Suicide Risk

- * Determine severity of stressors & suicide precipitants
- * Establish where patient is on continuum of suicidality
- * Identify accompanying psychopathology & associated risks
- * Assess how realistic the patient's plan is
- * Outline personal deterrents to committing suicide
- * Recognize limited benefit of labeling patient's behavior as manipulative
- * Consider situation awaiting patient after discharge
- * If unsure of level of risk, request a second opinion
- * Do not discharge an intoxicated patient
- * Document disposition and its rationale

Source: Adapted from Thienhaus and Piesecki 1997

Issues in making immediate treatment plans

First, do no harm. Do not provide the patient with medications that are potentially toxic in overdose.

Remove access to means of committing suicide. Assess whether a patient who is suicidal has access to a weapon. Family members can be asked to take charge of a weapon in the house, if necessary.

Offer the patient hope. Continuity of care and the quality and intensity of the treatment relationship are important factors that reduce suicide. In the emergency setting, help patients see that their problems can be solved and that you are personally willing and able to help.

Reference:

Allen MH (Editor): *Emergency Psychiatry* (Review of Psychiatry Series, Volume 21, Number 3; Oldham JM and Riba MB, series editors). Washington, DC, American Psychiatric Publishing, 2002.



Laboratory Screen in Psychiatry

Suggested for All Psychiatric Admissions

- Hematology group (HB, HCT, RBC indices, leukocyte count & differential, platelets)
- Chemistry group (electrolytes, LFTs, glucose, Ca, renal function tests, serum proteins)
- Serum B12 and folate
- Syphilis serology
- Thyroid function tests (total thyroxine and TSH)
- Erythrocyte sedimentation rate
- Urinalysis

Consider, Depending on Presentation

Blood

- HIV antibody screen
- Cortisol (AM and PM)
- Drug levels of psychopharmacologic agents
- Drug levels of agents of abuse
- Serum copper and ceruloplasmin
- Autoantibody screen and Ig's
- Cultures for infectious agents

Urine

- Urine drug abuse survey; urine screen for drugs or toxic agents
- 24-hour urine levels for lead, mercury, arsenic, other heavy metals
- 24-hour urine porphyrin levels
- Urinary metanephrines or 5-hydroxyindoleacetic acid
- Culture for infectious agents

Imaging

- *Computer tomography or magnetic resonance imaging of head
- *Chest radiography
- Cerebral angiography
- Cerebral blood flow studies

Other

- *Electrocardiogram
- Electroencephalogram
- Cerebrospinal fluid exam for cell count, cytology, glucose, protein, immunoglobulins, cultures
- *Neuropsychologic testing
- Karyotype, specific genetic tests (e.g., fragile X)
- Evoked potentials

If Alcoholism Is Suspected, Add

- Blood alcohol level
- γ -Glutamyltransferase
- Triglycerides

For Nutritionally Depleted Patients, Consider

- Zinc, copper, carotene, iron, or serum transferrin levels
- Triiodothyronine
- Total serum protein, albumin/globulin ratio
- Basal metabolic rate

**Suggested for evaluation of dementia.*



DSM-IV-TR (1 of 4)

Axis I	Clinical Disorders Other Conditions That May Be a Focus of Clinical Attention
Axis II	Personality Disorders Mental Retardation
Axis III	General Medical Conditions
Axis IV	Psychosocial and Environmental Problems
Axis V	Global Assessment of Functioning

Disorders Usually Diagnosed in Infancy, Childhood, or Adolescence

- **Mental Retardation** – mild, moderate, severe, profound, unspecified – *coded in Axis II*
- **Learning Disorder** – reading, mathematics, written, NOS
- **Motor Skills Disorder** – developmental coordination disorder
- **Communication Disorder** – expressive language, mixed receptive-expressive, phonological, stuttering, NOS
- **Pervasive Developmental Disorders** – autistic, Rett's, childhood disintegrative, Asperger's, NOS
- **Attention-Deficit and Disruptive Behavior Disorders** – ADHD, ADHD NOS, conduct disorder, oppositional defiant, disruptive behavior NOS
- **Feeding and Eating Disorders of Infancy or Early Childhood** – pica, rumination disorder, feeding disorder of infancy or early childhood
- **Tic Disorder** – Tourette's, chronic motor or vocal tic, transient tic disorder, NOS
- **Elimination Disorders** – encopresis, enuresis, nocturnal only / diurnal only / nocturnal & diurnal
- **Other Disorders of Infancy, Childhood or Adolescence**
 - **Separation Anxiety Disorder**
 - **Selective Mutism**
 - **Reactive Attachment Disorder of Infancy or Early Childhood** – inhibited or disinhibited type
 - **Stereotypic Movement Disorder** – w/ self-injurious behavior
 - **Disorders of Infancy, Childhood or Adolescence NOS**

Delirium, Dementia, and Amnestic and Other Cognitive Disorders

- **Delirium** – due to general medical condition, substance intoxication, substance withdrawal delirium, delirium due to multiple etiologies, NOS
- **Dementia** – Alzheimer's type or due to the ff: Creutzfeldt-Jakob, head trauma, Huntington's, HIV, Parkinson's, Pick's disease, substance-induced persisting, Vascular dementia due to other general medical conditions, multiple etiologies NOS
- **Amnestic Disorders** – due to a general medical condition, substance-induced persisting amnestic disorder, NOS
- **Other Cognitive Disorders**

Mental D/Os d/t a General Med Condition not Elsewhere Classified

Catatonic Disorder, Personality Change, Mental Disorder NOS



Substance-Related Disorders

- **Substance Use** – dependence, abuse
- **Substance-Induced Disorders** – intoxication, withdrawal, intoxication and withdrawal delirium, persisting dementia, amnesic disorder, psychotic disorder, mood disorder, anxiety disorder, sexual dysfunction, sleep disorder, NOS
- **Alcohol-Related Disorders**
- **Amphetamine (or Amphetamine-Like)-Related Disorders**
- **Cannabis-Induced Disorders**
- **Cocaine-Related Disorders**
- **Hallucinogen-Related Disorders**
- **Inhalant-Related Disorders**
- **Nicotine-Related Disorders**
- **Opioid-Related Disorders**
- **Phencyclidine (or Phencyclidine-Like)-Related Disorders**
- **Sedative-, Hypnotic-, or Anxiolytic-Related Disorders**
- **Polysubstance-Related Disorder**
- **Other (or Unknown) Substance-Related Disorders**

Schizophrenia and Other Psychotic Disorders

- **Schizophrenia** – catatonic, disorganized, paranoid, residual, undifferentiated
- **Schizophreniform Disorder**
- **Schizoaffective Disorder**
- **Delusional Disorder**
- **Brief Psychotic Disorder**
- **Shared Psychotic Disorder**
- **Psychotic Disorder Due to General Medical Condition** – w/ delusions, hallucinations
- **Substance-Induced Psychotic Disorder**
- **Psychotic Disorder NOS**

Mood Disorders

- **Mood Episodes** – major depressive, hypomanic, manic, mixed
- **Depressive Disorders** – dysthymic, major depressive, single episode or recurrent
- **Bipolar Disorders** – bipolar I, bipolar II, cyclothymic, NOS
- **Mood Disorder Due to general medical condition** – w/ depressive, manic or mixed features
- **Substance-Induced Mood Disorder**
- **Mood Disorder NOS**

Anxiety Disorders

- **Panic Disorders** – w/ or w/o agoraphobia
- **Agoraphobia** – w/o history of panic disorder
- **Specific phobia** – animal type, natural environment type, blood-injection-injury type, situational type, other
- **Social phobia**
- **Obsessive-compulsive disorder**
- **Posttraumatic stress disorder**
- **Acute stress disorder**
- **Generalized anxiety disorder**
- **Anxiety disorder NOS**



Somatoform Disorders

- Somatization Disorder
- Undifferentiated Somatoform Disorder
- Conversion Disorder
- Pain Disorder
- Hypochondriasis
- Body Dysmorphic Disorder
- Somatoform Disorder NOS

Factitious Disorders – psychological, physical, combined, NOS

Dissociative Disorders – amnesia, fugue, identity disorder, depersonalization disorder, NOS

Sexual and Gender Identity Disorders

- **Sexual Desire Disorders** – aversion, hypoactive
- **Sexual Arousal Disorders** – female sexual arousal, male erectile
- **Orgasmic Disorders** – female, male, premature ejaculation
- **Sexual Pain Disorders** – dyspareunia, vaginismus
- **Sexual Dysfunction due to general medical condition** – female or male dyspareunia, female or male hypoactive sexual desire disorder, male erectile disorder, other female or male sexual dysfunction, substance-induced dysfunction
- **Sexual Dysfunction NOS**
- **Paraphilias** – exhibitionism, fetishism, Frotteurism, pedophilia, masochism, sadism, transvestic fetishism, voyeurism, paraphilia NOS
- **Gender Identity Disorder** – children, adolescents or adults
- **Gender Identity Disorder NOS**
- **Sexual Disorder NOS**

Eating Disorders – anorexia nervosa, bulimia nervosa, eating disorder NOS

Sleep Disorders

- **Dyssomnias** – primary insomnia or hypersomnia, narcolepsy, breathing-related sleep disorder, circadian rhythm sleep disorder, NOS
- **Parasomnias** – nightmare, sleep terror, sleepwalking, NOS
- **Sleep Disorders Related to Another Mental Disorder**

Impulse-Control Disorders Not Elsewhere Classified

– Intermittent explosive disorder, kleptomania, pathological gambling, pyromania, trichotillomania, NOS

Adjustment Disorders – w/ depressed mood, anxiety, disturbance of conduct, mixed anxiety & depressed mood, mixed disturbance of emotions & conduct, unspecified



Axis II: Personality Disorders

Cluster A	Paranoid, Schizoid, Schizotypal
Cluster B	Antisocial, Borderline, Histrionic, Narcissistic
Cluster C	Avoidant, Dependent, Obsessive-Compulsive
Personality Disorder NOS	

Other conditions that may be a focus of clinical attention

Psychological Factors Affecting Medical Condition

Medication-Induced Movement Disorders – Neuroleptic Induced Parkinsonism, Neuroleptic Malignant Syndrome, Neuroleptic Induced Acute Dystonia, Neuroleptic Induced Acute Akathisia, Neuroleptic Induced Tardive Dyskinesia, Medication Induced Postural Tremor, Medication-Induced Movement Disorder NOS

Other Medication-Induced Disorder – NOS

Relational Problems – related to mental disorder or general medical condition, parent-child, partner, sibling, NOS

Problems Related to Abuse and Neglect – physical abuse of child, sexual abuse of child, neglect of child, physical abuse of adult, sexual abuse of adult

Additional Conditions that may be a focus of clinical attention – noncompliance w/ treatment, malingering, adult antisocial behavior, child or adolescent antisocial behavior, borderline intellectual functioning, age-related cognitive decline, bereavement, academic problem, occupational problem, identity problem, religious or spiritual problem, acculturation problem, phase of life problem

