Approach to the Patient With Mental Symptoms

Introduction

Patients with mental complaints or concerns or disordered behavior present in a variety of clinical settings, including primary care and emergency treatment centers. Complaints or concerns may be new or a continuation of a history of mental problems. Complaints may be related to coping with a physical condition or be the direct effects of a physical condition. The method of assessment depends on whether the complaints constitute an emergency or are reported in a scheduled visit. In an emergency, a physician may have to focus on more immediate history, symptoms, and behavior to be able to make a management decision. In a scheduled visit, a more thorough assessment is appropriate.

Routine Psychiatric Assessment

http://mkdiagnostics.com/software/psychiatric-evaluation-system/

History

The physician must determine whether the patient can provide a history, ie, whether the patient readily and **coherently** responds to initial questions. If not,

information is sought from family and caregivers. Even when a patient is communicative, close family members, friends, or caseworkers may provide information that the patient has omitted. Receiving information that is not **solicited** by the physician does not violate patient confidentiality. Previous psychiatric assessments, treatments, and degree of **adherence** to past treatments are reviewed, and records from such care are obtained as soon as possible.

Conducting an interview hastily and indifferently with **closed-ended queries** (following a rigid system review) often prevents patients from revealing relevant information. Tracing the history of the presenting illness with **open-ended questions**, so that patients can tell their story in their own words, takes a similar amount of time and enables patients to describe associated social circumstances and reveal emotional reactions.

The interview should first explore what prompted the need (or desire) for psychiatric assessment (eg, unwanted or unpleasant thoughts, undesirable behavior). The interviewer then attempts to gain a broader perspective on the patient's personality by reviewing significant life events—current and past—and the patient's responses to them (see Table 1: Approach to the Patient With Mental Symptoms: Areas to Cover in the Initial Psychiatric Assessment). Psychiatric, medical, social, and developmental history is also reviewed.

Table 1

Areas to Cover in the Initial Psychiatric Assessment

Area	Some Elements
Psychiatric history	Known diagnoses Previous treatments, including drugs and hospitalizations
Medical history	Known disorders Current drugs and treatments
Social history	Education level Marital history, including quality and stability of marriage Employment history, including stability and effectiveness at work Legal history, including arrests and **incarcerations** Living arrangements (eg, alone, with family, in group home or shelter, on street) Pattern of social life (eg, quality and frequency of interaction with friends and family)
Family health history	Known diagnoses, including mental disorders
Response to the usual vicissitudes of life	Divorce, job loss, death of friends and family, illness, other failures, **setbacks**, and losses

Developmental history	Family composition and atmosphere during childhood Behavior during schooling Handling of different family and social roles Sexual adaptation and experiences
Daily conduct	Use or abuse of alcohol, drugs, and tobacco Behavior while driving
Potential for harm to self or others	Suicidal thoughts and plans Intent to harm others

The personality profile that emerges may suggest traits that are adaptive (eg, **resilience**, **conscientiousness**) or **maladaptive** (eg, **self-centeredness**, dependency, poor tolerance of frustration) and may show the **coping mechanisms** used. The interview may reveal obsessions (unwanted and **distressing** thoughts or impulses), **compulsions** (urges to do irrational or apparently useless acts), and **delusions** (fixed false beliefs) and may determine whether distress is expressed in physical symptoms (eg, headache, abdominal pain), mental symptoms (eg, phobic behavior, depression), or social behavior (eg, **withdrawal**, rebelliousness). The patient should also be asked about attitudes regarding psychiatric treatments, including drugs and psychotherapy, so that this information can be incorporated into the treatment plan.

The interviewer should establish whether a physical condition or its treatment is causing or worsening a mental condition. In addition to having direct effects (eg, symptoms, including mental ones), many physical conditions cause enormous stress and require coping mechanisms to withstand the pressures related to the condition. Most patients with severe physical conditions experience some kind of adjustment disorder, and those with underlying mental disorders may become unstable.

Observation during an interview may provide evidence of mental or physical disorders. Body language may reveal evidence of attitudes and feelings denied by the patient. For example, does the patient **fidget** or pace back and forth despite denying anxiety? Does the patient seem sad despite denying feelings of depression? General appearance may provide clues as well. For example, is the patient clean and well-kept? Is a **tremor** or **facial droop** present?

Mental Status Examination

A mental status examination uses observation and questions to evaluate several domains of mental function, including speech, emotional expression, thinking and perception, and **cognitive functions**. Brief standardized screening questionnaires are available for assessing certain components of the mental

status examination, including those specifically designed to assess orientation and memory. However, screening questionnaires cannot take the place of a broader, more detailed mental status examination.

http://thehillsclinic.com.au/hospital/

General appearance should be assessed for unspoken clues to underlying conditions. Patients' appearance can help determine whether they are unable to care for themselves (eg, they appear **undernourished**, **disheveled**, or dressed inappropriately for the weather or have significant body odor), are unable or unwilling to comply with social norms (eg, they are **garbed** in socially inappropriate clothing), or have engaged in substance abuse or attempted self-harm (eg, they have an odor of alcohol, scars suggesting IV drug abuse or self-inflicted injury).

Speech can be assessed by noting spontaneity, syntax, rate, and volume. A patient with depression may speak slowly and softly, whereas a patient with mania may speak rapidly and loudly. Abnormalities such as **dysarthrias** and **aphasias** may indicate a physical cause of mental status changes, such as head injury, stroke, brain tumor, or multiple **sclerosis**.

Emotional expression can be assessed by asking patients to describe their feelings. The patient's tone of voice, posture, hand gestures, and facial expressions are all considered. Mood (emotions patients report) and affect (emotional state interviewer notes) should be assessed.

Thinking and perception can be assessed by noticing not only what is communicated but also how it is communicated. Abnormal content may take the form of delusions (false, fixed beliefs), ideas of reference (notions that everyday occurrences have special meaning or significance personally intended for or directed to the patient), or **obsessions**. The physician can assess whether ideas seem to be linked and goal-directed and whether transitions from one thought to the next are logical. Psychotic or manic patients may have disorganized thoughts or an abrupt flight of ideas.

Cognitive functions include the patient's level of alertness; attentiveness or concentration; orientation to person, place, and time; memory; abstract reasoning; insight; and judgment. Abnormalities of cognition most often occur with **delirium** or **dementia** or with substance abuse or withdrawal but can also occur with depression.

Reference: http://www.merckmanuals.com