PSYCHIATRY

THIRD EDITION

JANIS L. CUTLER

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Psychiatry

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To RCP, with love

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INTRODUCTION

Psychiatry is the field of medicine that concerns itself with those illnesses that have emotional or behavioral manifestations. Psychiatric illnesses are extremely common and exact a great personal and social cost in disability, suffering, and even death. This book is intended as an introductory text that prepares medical students, physicians, and other health professionals for the clinical task of working with psychiatric patients. As such, it emphasizes recognition and assessment of psychiatric illness. The text's clinical orientation is equally well suited for medical students during their preclinical introduction to psychiatry course and core psychiatry clerkship, as well as nonpsychiatric physicians, psychiatric residents, and other health professionals who work with patients with psychiatric disorders, including psychologists, social workers, nurses, and occupational therapists.

Patients with emotional and behavioral difficulties are often discouraged from seeking help by the stigma that they, their families, and even physicians tend to attach to psychiatric illnesses. All health care providers should be sensitive to the shame that patients with psychiatric problems may have. Being well informed about the signs and symptoms of the most common psychiatric disorders improves the physician's chances of recognizing these disorders in patients. Familiarity with the course and prognosis of these conditions enhances the ability to refer patients for appropriate treatment and to complete the first step in the referral process, which is frequently education and reassurance.

The first two chapters in the book provide a framework for the evaluation of psychiatric patients, focusing on clinical assessment and the psychiatric interview. These chapters demonstrate how to obtain and synthesize clinical data and generate an appropriate differential diagnosis and treatment plan. Subsequent chapters cover the major psychiatric disorders; the special topics of suicide, violence, and the medically ill patient; and an overview of the stages of child, adolescent, and adult development. An additional chapter is devoted to the assessment and treatment of children and adolescents. The book concludes with chapters covering pharmacotherapy and psychotherapy.

DIAGNOSTIC AND CLINICAL FEATURES

The use of diagnostic categories has a particular history in psychiatry, and over the past several decades, the field has been concerned with improving diagnostic reliability and consistency. Throughout this book, reference is made to the *Diagnostic and Statistical Manual of Mental Disorders,* 5th edition (DSM-5), which is published by the American Psychiatric Association, the professional organization of psychiatrists in the United States. The publication of the DSM-5 in 2013 incorporates a more dimensional approach to psychiatric diagnosis. Previous editions of the DSM had used a polythetic approach

(i.e., more than one combination of symptoms will qualify for a particular diagnosis). The aim of the DSM system is descriptive. It is the best and most widely referenced psychiatric diagnostic system currently available. It is not, however, a perfect system but rather an evolving one. Ultimately, the criteria are intended only as guidelines for physicians who must use their own best judgment in making an appropriate diagnosis.

THE INTERVIEW

In all of medicine the clinical interview is the basis by which diagnoses are made and therapeutic alliances between patients and physicians are forged. Even in this age of advanced medical technology, no sophisticated test can take the place of a careful, complete history that is empathically obtained. Clinical interviewing as a sophisticated art is perhaps nowhere more apparent than in psychiatry. The central importance of the clinical psychiatric interview is reflected in the central positioning of a section devoted to the interview, accompanied by Interviewing Guideline summaries, in each disorder chapter.

ETIOLOGY

As in the rest of medicine, the description of psychiatric syndromes and their effective treatments has generally preceded an understanding of their pathophysiology and etiology. The past several decades has witnessed an explosion in the understanding of some of the neurobiological mechanisms that underlie many psychiatric disorders. Advances in neuroimaging, molecular genetics, and other basic science techniques hold the promise for even more knowledge in the not too distant future. But enthusiasm must be tempered by the sobering realization that the mind and the ways in which it can become disturbed are exceedingly complex—so much so that, for example, researchers struggling to understand the etiology of schizophrenia have compiled many probably significant but currently isolated observations and thus do not seem to be much closer to solving the mystery of how and why 1% of the world's population is afflicted with this devastating illness.

Some in the field have worried that the emphasis on neurobiology has replaced the previous tradition of the biopsychosocial model, which attempts to consider the whole patient, encompassing a biologically endowed human being with a particular psychology and social context. Psychiatrists continue to struggle with the issue of how much of an effect external factors such as family, environment, and psychic trauma have on the onset and course of psychiatric disorders. A fundamental assumption of this book is that, in the "nature versus nurture" debate, both sides have validity: Genetic loading and intrauterine exposure may play important roles in the etiology of many psychiatric disorders, but interpersonal, developmental, and other "nurture" issues seem to be crucial as well.

TREATMENT

Patients come to physicians and other health professionals to receive help. Treatment planning requires a collaborative effort between patient and clinician. While detailed treatment guidelines are beyond the scope of this book, a summary of specific treatment options available for each of the major psychiatric illnesses, including psychotherapeutic and pharmacotherapeutic modalities, is provided. Psychiatry's strong clinical tradition should serve its patients and the entire field of medicine well. It is the intent of this book to provide the practicing clinician with a foundation that is biopsychosocially based and psychiatrically well informed.

USE OF THE BOOK

We have strived to maintain an appropriate balance between thoroughness and ease of use. Clinical illustrations, included to bring the material to life, are set off from the main text. Essential information is highlighted in tables and with key words to allow *Psychiatry*'s use as a resource for successful exam preparation.

/// 1 /// Psychiatric Assessment and Treatment Planning

JANIS L. CUTLER

When patients come to physicians with complaints and concerns, they hope to receive help, comfort, and information. They do not necessarily think in terms of diseases or syndromes, and they frequently do not know what information about themselves and their problems physicians need to have. Patients initially describe and organize their complaints and concerns in a way that makes sense to themselves. The presentation varies from patient to patient and is affected by many factors, including their medical knowledge, level of anxiety, coping and defense mechanisms, and attitude toward physicians. Physicians should listen to the complaints from the patient's perspective and add their own questions and observations to develop a complete picture of the patient's problems, resources, and strengths, which will facilitate treatment planning. In psychiatric assessment, both the diagnosis (which categorizes conditions according to signs and symptoms) and the description of patients' strengths and vulnerabilities (i.e., what makes them unique) play important roles in determining the best treatment approach.

The psychiatric case write-up is an essential means of communication among health care professionals who may be involved in the patient's treatment. It also serves as documentation of the physician's evaluation (patients and other parties, such as insurance companies and the courts, may be able to gain access to the written psychiatric case formulation, which is a legal and official part of patients' medical records).

The case write-up should reflect the process of case formulation and involves a number of steps, which also serve to organize the write-up (see Figure 1.1). The focus varies, depending on the **setting** in which the patient is being evaluated and the **goals** of the interview (which relate to the chief complaint). The quantity and depth of information in the case write-up also vary. The write-up may be based on a brief emergency room interview, a one-hour outpatient visit, an extensive outpatient evaluation consisting of several sessions, or days to weeks of inpatient sessions. In general, the less time spent with the patient, the less information available for the assessment and the more questions that will be left unanswered in the formulation. The written record may be an admission note to an inpatient unit or day program, an off-service note (summarizing treatment by the previous staff when psychiatrists change), an outpatient evaluation summary, or a discharge

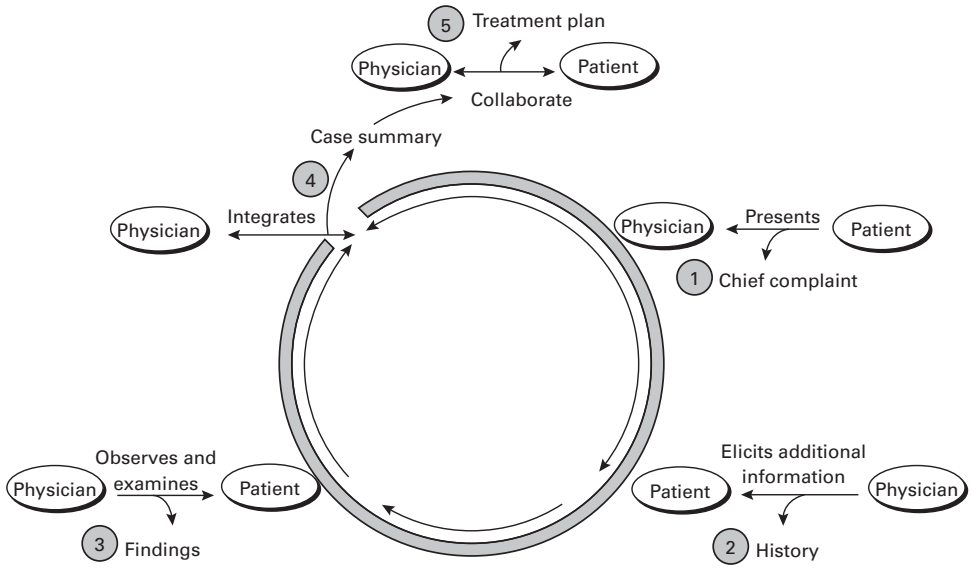

FIGURE 1.1 Steps in creating the case write-up. (1) The patient presents the chief complaint to the physician. (2) As the interview proceeds, the physician elicits additional information from the patient in order to obtain the history of the present illness and the past psychiatric history, medical history, psychosocial history, and family history. The physician also conducts a review of systems. (3) Findings from the physical examination, mental status examination (including how the patient relates to the physician), and laboratory and other test results are collected. (4) The physician then integrates all of the information and generates a descriptive and diagnostic impression. (5) Together, the patient and physician create a theoretically sound and feasible treatment plan.

summary (a review of completed treatment course, usually of an inpatient). Every institution has its own requirements and vocabularies for case formulations, but the objectives are always the same: the case write-up communicates the physician's understanding of a patient and his or her needs to other clinical staff persons and helps the physician and staff crystallize this information and integrate it into a treatment plan.

A psychiatric case write-up is recorded in the same format as a medical case write-up, with some modifications (see Table 1.1). If a patient is seen more than once, additional sections may be added to indicate the course of the patient throughout the evaluation process or hospital admission, including all changes in symptoms and functioning.

The case material is rarely organized in the way the patient presents it in the interview. In fact, beyond the basic headings, almost invariably it is not. The written record more closely reflects the organization and thought processes of the physician as he or she comes to understand and integrate the patient's problems. The interview and the written formulation do, however, begin at the same place: the chief complaint.

CHIEF COMPLAINT

The chief complaint is the reason the patient gives for seeking help. It does not necessarily reflect the problem that the patient needs help with most—in fact, the chief complaint may be misleading (see Box 1.1). Patients with the same disorder may nonetheless

TABLE 1.1 Components of the Case Write-up

Identifying information (ID)
Age
Relationship/marital status
Occupation/source of support
Chief complaint (CC)
History
History of the present illness (HPI)
Past psychiatric history
Past medical history (PMH)
Current medications
Review of systems (ROS)
Psychosocial history
Family history (FH)
Findings
Physical examination (PE)
Mental status examination (MSE)
Laboratory and other tests
Impression
Case summary
Differential diagnosis
Predisposing and precipitating factors
Treatment plan
Prognosis

BOX 1.1

MISLEADING CHIEF COMPLAINTS

A patient who complains of feeling "nervous," a seemingly innocuous symptom, may be suffering from a number of psychiatric disorders, ranging from depression to psychosis. A man whose chief complaint is that he is "losing his mind" is just as likely, if not more so, to be suffering from panic attacks as from psychosis. One elderly man who had little formal education, no history of mental illness, and a tendency to be unaware of his emotional state gave this initial description of what turned out to be a clear-cut case of depression: "I'm not long for this world—I'm very weak, I have a funny feeling in my stomach, my head is full, I can't eat or sleep."

BOX 1.2

DIFFERENT CHIEF COMPLAINTS FOR IDENTICAL PROBLEMS

Two middle-aged women noticed breast lumps and made appointments with their internists. One woman's chief complaint was fatigue. She "forgot" the lump until her physician began to examine her. At that time, she mentioned the lump, which was of much more concern to her, and to her physician, than the fatigue, which may have been related to her worry about the lump and may not have had a more specific basis. The second woman's "chief complaint" was the lump, which she talked about in a straightforward manner, complete with her own assessment of the diagnostic possibilities.

Arriving at an overall formulation for these two patients involves different processes, although the "differential diagnosis" is the same: cyst, benign tumor, or malignant tumor. For one patient, the true chief complaint is easily identified; for the other, it nearly slips by without mention. Each woman's unique response to her anxiety-provoking symptom is reflected in her presenting complaint and should be included in the case summary and overall formulation: one woman tends to use denial as a coping mechanism when she is under stress; the other, intellectualization (see Box 17.3, Chapter 17, Psychotherapy). Their different responses will also be reflected in their treatment plans. The denial of the first patient could impede a prompt workup and should be regarded as part of the problem, not necessarily to be changed but certainly to be kept in mind. The intellectualization of the second patient can be regarded as a strength to be used by her and her physician as the evaluation proceeds. If both of these women are eventually diagnosed with invasive cancer with widespread metastases, a defensive personality style that had been detrimental could become a strength, and vice versa (denial may be helpful when a patient is facing a terminal illness, whereas intellectualization, although it contributes to the patient's understanding of the illness, may block an associated emotional reaction and make the patient more vulnerable to depression).

give entirely different chief complaints (see Box 1.2). The chief complaint is generally recorded in the patient's own words.

HISTORY

History of the Present Illness

The physician begins the interview by eliciting the history of the present illness, starting with the chief complaint (keeping in mind that it may be misleading) and working backward. The physician allows the interview to follow any number of different paths, depending on the patient's leads and the physician's intuition, in order to develop a **chronological, systematic outline** of the **signs and symptoms** of the current episode, which culminated in the patient's decision to come for help. Explanations as to why the patient has come for help at this time (i.e., **why *now***) and why the need for help is

presented in the way that it is are crucial to the history. Only when this history-taking process is complete do the "present illness" and its chronology become apparent. The history of the present illness is best composed after the differential diagnosis has been generated because the history should support the differential diagnosis. Attempting to complete the written assessment while interviewing the patient usually results in a confused record that lacks the integration and synthesis required, by definition, for a formulation, because the physician has not had sufficient time to process the information before recording it.

If the patient's current episode of illness exists within the context of a chronic psychiatric syndrome, the history of the present illness can begin with the symptoms of the first episode of illness ever experienced, *or* with the current exacerbation, leaving the early symptoms and previous episodes to be summarized in the past history. If the diagnosis is unclear or should be modified, it may be most useful for the history of the present illness to cover the entire illness course of the illness. If the diagnosis has been clearly established, previous episodes can be summarized in the past psychiatric history section. In addition, if the current episode is complex, it may be simplest to include previous episodes in the past history.

Eliciting a history from patients with **personality disorders** is often challenging because the maladaptive patterns of behavior and emotional responses characteristic of personality disorders tend to be **egosyntonic** (i.e., understood by the individual as part of her or her personality and not the result of a disease process), in contrast to the egodystonic symptoms characteristic of most other psychiatric disorders, which patients regard as foreign and separate from themselves. Patients with personality disorders may have great difficulty in articulating their problems (see Chapter 8, Personality Disorders). When a personality disorder is suspected, the physician should conduct the interview in a way that allows the patient's **interpersonal relationships,** as well as certain aspects of his or her inner life, to be assessed (see Box 1.3).

The history of the present illness should include **brief specific examples** to illustrate particular problems. **Pertinent negatives** should be included as well. The list of symptoms and conditions that have not been present should not be all-inclusive. In fact, not all of the information obtained in the interview should be recorded. Instead, positive and negative findings should be of sufficient detail to provide someone reading it with the information necessary to generate a case formulation but should not contain extraneous information. It can be a challenge to know what is important and what is not, what fits a particular clinical pattern and should be highlighted, what fits but is of secondary importance, what does not fit but should be included because it is so significant that it calls the working diagnosis into question, and what does not fit but can be minimized because it is probably a spurious finding. Informed focusing can be difficult, but it is the goal. A clearly formulated, well-presented history should lead all readers to generate the same differential diagnosis.

Past Psychiatric History

The past psychiatric history should include descriptions of **previous episodes of psychiatric illnesses**, the **treatment** received, the **outcome** of that treatment, and pertinent negatives. The presence or absence of prior hospitalizations, instances of impaired impulse control, and suicidal and homicidal ideation should *always* be included. Historical information particularly relevant to the current clinical questions should be addressed (see Box 1.4).

BOX 1.3

HISTORY OF A PATIENT WITH A PERSONALITY DISORDER

BACKGROUND

A 25-year-old graduate student complaining of "depression" described a confusing mixture of vague symptoms, which she subsequently dismissed. She presented long, overly detailed complaints about people in her life who were not clearly differentiated from one another. During the interview, the physician focused on the patient's distorted perceptions of others, her inability to describe herself in a coherent fashion, her self-destructive behavior, and her chronic feelings of emptiness. A clinical picture of borderline personality disorder gradually emerged. Although the written history of the present illness and the past history will not reflect the confusion of the first half of the interview, the physician may comment on the patient's circumstantiality and tangentiality in the mental status examination portion of the case formulation.

HISTORY

The patient reports chronic feelings of emptiness. She avoids being alone at all costs and experiences intense anxiety when she is alone. She has repeatedly engaged in self-destructive behavior, including superficially cutting her arm with a razor blade. The patient denies substance abuse and suicide attempts. Her patterns of relationships have been stormy. She rapidly becomes involved in intense relationships and then, just as quickly, becomes disillusioned with and enraged by the same person she had been idealizing. In one instance, she began meeting several times a week with one of her male professors, initially talking about course work and issues relevant to her field of interest but soon confiding in him about her personal concerns. She saw him as warm and supportive, "a treasure." After one occasion when he had to cut an appointment short, she became furious and reported, "I thought he was special, but he's just like everyone else—selfish and self-centered."

COMMENT

This history of the present illness summarizes the patient's narrative in a succinct manner that facilitates arriving at the appropriate diagnosis. Without directly referring to the diagnostic criteria, the history of the present illness points the reader in the general direction of a personality disorder, and specifically to the diagnosis of borderline personality disorder. This focus is a conscious editorial decision on the part of the interviewer. In other situations, it would not be necessary or appropriate to include such detailed information about the patient's relationships.

Past Medical History

The past medical history is an essential part of all psychiatric case formulations. Many medical conditions have direct psychiatric manifestations (see Chapter 5, Neurocognitive Disorders and Mental Disorders Due to Another Medical Condition). Chronic illnesses such as diabetes, asthma, and arthritis, as well as acute and short-lived but stressful

BOX 1.4

PAST PSYCHIATRIC HISTORY

A patient who had had schizophrenia for 10 years suffered a psychotic exacerbation after the sudden death of her mother. She presented to the emergency room with this chief complaint: "I'm hearing voices telling me to kill myself." The woman had been followed since the onset of her illness by a psychiatrist who was on the staff at the same hospital. Her past history was clearly documented in previous chart entries and could be briefly summarized in the current case formulation, highlighting the information that was most relevant for the decisions to be made: Has the patient been suicidal before? Has she ever had command auditory hallucinations? Has she acted on them or done anything to hurt herself? Has she had to deal with other losses, and, if so, how did she do so? Is she usually adherent to treatment? This information should be the focus of the past psychiatric history. In other words, this patient's history of difficulty dealing with loss and impulse control is more essential than is a complete review of her previous psychotic symptoms. It is important to remember that the purpose of the written record is to communicate needed information.

medical events such as an emergency appendectomy or severe pneumonia requiring hospitalization, may be significant stressors with which patients must cope (see Chapter 11, Psychological Factors Affecting Medical Conditions). The patient's approach to health and illness and to physicians, including issues such as adherence to prescribed treatments and avoidance of prohibited risk-taking behaviors such as smoking, can be elicited in the context of the past medical history.

Review of Systems

The review of systems, as the name implies, records the **presence or absence of current symptoms** in each **major organ system**, including the central nervous system. Psychiatric and medical symptoms that appear to be *unrelated* to the patient's present illness should be recorded in this section of the case formulation (see Chapter 2, The Psychiatric Interview, for suggestions on eliciting a comprehensive psychiatric review of systems, and *DeGowin's Diagnostic Evaluation* [LeBlond and Brown 2009] for suggestions on conducting a medical review of systems).

Psychosocial History

The psychosocial history encompasses the patient's **childhood, adolescence, and adulthood**. The childhood history should address any unusual findings with regard to childbirth, infancy, and the attainment of **developmental milestones**. Profiles of significant people present in the family during childhood should be obtained, as well as the family atmosphere, including conflicts, **losses**, and changes in the status of significant adults. Inquiries must always be made about the possibility of **physical and sexual abuse**.

An **educational history**, including performance at school, and a description of **peer relationships** should be obtained. **Childhood illnesses** and symptoms should be noted. **Earliest memories** can sometimes be useful.

A picture of school and occupational functioning, friendships, and intimate relationships should be provided for adolescence and adulthood. The **sexual history** and **alcohol and drug history** are generally included in this section. Whereas the other sections of the case formulation tend to focus on disease and disability, the psychosocial history should include **areas of health** and **strength** (see sample in Box 1.5).

Assessment of the patient's **cultural identity** is an important aspect of the psychosocial history. This will include the culture in which the patient was raised (i.e., **ethnic** and **religious** background), current **cultural reference groups, language** abilities, and cultural conceptualizations of **distress** and **coping**.

BOX 1.5

SAMPLE PSYCHOSOCIAL HISTORY

BACKGROUND

The patient is a 19-year-old woman who was admitted to an inpatient unit with the diagnosis of an eating disorder. While the following psychosocial history is not all-inclusive, the information provided is important for understanding the patient as an individual and will contribute to an initial treatment plan, part of which may be to obtain further information to fill in some of the gaps.

The patient is the youngest of three children born to middle-class parents living in an affluent suburb. Her father, who teaches college biology, is a nervous, suspicious man, who gets drunk every night in front of the television set. Her attractive mother dominates the family and participates in an active social life. The patient's two sisters have been successful academically, athletically, and socially and are currently at various stages of completing graduate work at Ivy League schools. Her family is superficially warm and supportive, but the emphasis is apparently on remaining pleasant to the exclusion, as much as possible, of any problems or bad feelings.

The patient describes herself as having been a withdrawn and shy child. She felt excluded from, and inferior to, her peers and frequently stayed home, complaining of "stomach aches." She was a good student, nonetheless, earning grades of B+ and A. During adolescence, with her mother's coaching, she became popular, participating in extracurricular activities with a circle of superficial friends whom she would go out of her way to please. She spent weekends "partying," abusing alcohol, amphetamines, cocaine, and marijuana. She was "never without a boyfriend," molding herself to her latest boyfriend's specifications in order to be the "perfect girlfriend," and she became sexually active. After graduation from high school, she attended a prestigious college several hundred miles away, where she immediately felt lonely and out of place. She left after her first semester and spent the rest of the year isolated at home.

BOX 1.6

PARALLEL PSYCHOSOCIAL HISTORY

A woman in her thirties reported that her depression occurred in March of 2012 and then later stated that her mother died in December of 2012. When the physician double-checked this sequence, the patient corrected the physician, and her own dates, with surprise, saying, "The depression must have been in March of 2013, because it was definitely after my mother's death." Patients are not necessarily aware of these connections and sequences, but they may be of great importance. For example, a man in his fifties presented with a depression. While obtaining a parallel psychosocial history, the physician learned that the patient's father was dying of cancer. When the physician raised the possibility that the patient might be "upset" about his father's impending death (but did not suggest that the depression might be causally related), the patient completely denied any such reaction, insisting that he was prepared for his father's death because his father had been ill for several years and was in his eighties. Later in his treatment it became apparent that the patient had an ambivalent relationship with his father and that his impending death was, indeed, having a profound impact on him.

It can be extremely helpful to note the **timing of events** in the personal history in **parallel** with the timing of events in the patient's psychiatric history. While obtaining the personal history, the physician should keep in mind the key psychiatric events in the patient's life and make note of when they occur in relation to life circumstances. Important errors can be made if the physician does not specifically inquire about this sequence (see case examples in Box 1.6).

Family History

While some family information will be included in the psychosocial history, the presence or absence of psychiatric disorders in first-degree relatives should be noted in the family history section of the case formulation.

MENTAL STATUS EXAMINATION

The mental status examination is the most essential part of the "findings" section of the case write-up. It is comprised of **observed** data, in contrast to the subjectively reported history. The mental status examination is an **objective description** of an individual's **current mental state**, based on his or her speech and behavior. The format of the mental status examination provides a particular structure for listening, observing, and recording (see summary of major categories in Table 1.2 and definitions of mental status examination findings in Table 1.3). Like the physical examination, the mental status examination **does not include historical information**, nor does it include subjective complaints (with the exception of mood, see definition). The mental status examination is recorded in a systematic fashion following a **standard structure** with specific headings

TABLE 1.2 Mental Status Examination

Category	Definition	Common "Normal" Descriptors	"Abnormal" Descriptors (see definitions of individual items in Table 1.3)
Appearance, behavior, speech, and attitude	A detailed description of the individual as he or she appears during the clinical encounter, including grooming and clothing; motor behavior; the rate, volume, and modulation of speech and interactions with the interviewer	See sample mental status examination in Box 1.7	
Mood	Subjective feeling state of the individual sustained over much of the interview	Euthymic	Depressed (dysthymic), sad, irritable, expansive, euphoric, nervous, angry
Affect	Objective description of the individual's emotional state as observed by the clinician	Full range	Constricted, blunted, flat, inappropriate, labile
Thought process	The organization of the individual's thoughts as reflected in his or her verbal productions	Coherent and goal directed	Tangential, circumstantial, flight of ideas, loosening of associations, word salad, blocking, neologisms
Thought content	Overt signs and symptoms of psychopathology; the themes of the individual's thoughts during the interview should be mentioned only if preoccupations and ruminations are present; presence or absence of delusions, suicidal and homicidal ideation should always be included	No evidence of delusions; denies obsessions and suicidal and homicidal ideation	Presence of delusions (specify type—grandiose, paranoid, somatic, religious, reference), overvalued ideas (including paranoid ideation and ideas of reference), obsessions, ruminations, suicidal and homicidal ideation; paucity of thought—describe and give examples
Perception	Assessment of perceptual symptoms: illusions, depersonalization, derealization, hallucinations	Denies auditory and visual hallucinations	Specify type of hallucination (auditory, visual, olfactory, tactile) and describe
Cognitive	Assessment of the individual's abilities with regard to attention and orientation as well as intellectual functions, including memory, calculations, fund of knowledge, and capacity for abstract thought	Alert, attentive, and oriented × 3. Describe findings of each test administered (see Chapter 5, Neurocognitive Disorders and Mental Disorders Due to Another Medical Condition)	
Insight	The individual's understanding of himself or herself in the context of wanting or needing help; also referred to in psychodynamic terms as "observing ego"	Intact, excellent	Fair, impaired (include explanation)
Judgment	Closely related to insight but refers specifically to actions the individual will take based on insight; usually reflects impulse control	Intact, excellent	Fair, impaired (include explanation)

TABLE 1.3 Definitions of Mental Status Examination Findings

Descriptor	Definition
Behavior	
Psychomotor agitation	Noticeable and marked increase in body movements, e.g., hand wringing, pacing
Psychomotor retardation	Significant slowing of speech and body movements, lack of usual fidgetiness
Mood	
Expansive	Enthusiastic
Euphoric	Feeling great, as if one just won the lottery
Affect	
Blunted	Decrease in amplitude of emotional expression
Constricted	Normal amplitude but restricted range
Flat	Virtually complete absence of affective expression
Inappropriate	Emotions expressed are not congruent with content of patient's thoughts (occasional nervous smiling or laughter is not sufficient)
Labile	Unpredictable shifts in emotional state
Thought Process	
Circumstantial	Organized but overly inclusive, eventually gets to the point in a painstakingly slow manner
Tangential	Occasional lapses in organization such that the patient suddenly changes the subject and never returns to it; if a question is asked, it isn't answered
Flight of ideas	Flow of thoughts is extremely rapid but connections remain intact
Loosening of associations	Frequent lapses in connection between thoughts, disorganized
Word salad	Incomprehensible speech due to lapses in connections even within a single sentence; incoherent, a "tossed salad" of ideas
Blocking	Patient loses his or her train of thought; by definition, the patient should confirm the subjective experience of being blocked; the term should not be based on the interviewer's observation alone
Neologism	A created word with an idiosyncratic meaning
Thought Content	
Delusion	A firmly held, false belief not shared by members of the patient's culture (by definition, reality testing is not intact, i.e., the patient is unable to consider the possibility that the belief is incorrect)
Obsession	An idea that is intrusive and egodystonic (by definition, reality testing is preserved, i.e., the patient will readily acknowledge that the obsession makes no sense); should not be confused with ruminations, which are egosyntonic, or delusions
Overvalued idea	A false belief not shared by members of the patient's culture that is not fixed, i.e. it is held to more firmly than one would expect but reality testing is maintained
Paranoid ideation	Specific type of overvalued idea characterized by suspiciousness about others' motives
Ideas of reference	Specific type of overvalued idea characterized by misinterpretation of external events as having particular meaning for the individual
Phobia	A specific fear that results in avoidance of a situation despite the individual's realization that the fear is irrational

(continued)

TABLE 1.3 Continued

Descriptor	Definition
Perception	
Illusion	Misinterpretation of a sensory stimulus that can occur in any sensory modality (e.g., misperceiving billowing curtains in a darkened room to be an intruder)
Hallucination	Perceiving a sound, sight, taste, smell, or touch in the absence of external sensory stimulation that seems indistinguishable from such an experience in reality
Depersonalization	The sense that one is outside of oneself
Derealization	A vague sense of unreality in one's perception of the external world

(see guidelines in Table 1.4). **Detailed descriptions** should be included, interspersed with carefully chosen examples and brief patient quotes. **Pertinent negative findings** should be included, as they are in the history section. Common physical examination descriptors such as "within normal limits" or "well developed, well nourished" do not belong in the recorded mental status examination, as they do not adequately convey how a particular individual appeared, behaved, and sounded, even if the mental status examination is "normal." On the other hand, an overly inclusive written report is not useful in providing a clear description of an individual's unique mental status. A wealth of information can be efficiently conveyed by a well-organized, descriptive, and concise mental status examination (see sample mental status examination within the Sample Case Write-up in Box 1.7).

OTHER FINDINGS

Physical Examination

A thorough physical examination should be performed and documented in the case formulation for all psychiatric patients. The physical examination should be thorough because, even if there are no neurological findings, a systemic illness may be present that is producing psychiatric symptoms. Patients with clear-cut psychiatric disorders can also have other medical conditions that can be missed if a thorough physical examination is not performed. Vital signs and a detailed neurological examination are of particular importance.

TABLE 1.4 Guidelines for Recording the Mental Status Examination

- Objectively describe the patient's current mental state.
- Convey a clear description of the patient's unique mental status examination.
- Provide detailed descriptions, including examples and brief patient quotes.
- Record information systematically, following a standard structure with specific headings.
- Identify positive findings and psychopathology.
- Mention pertinent negatives.
- Include assessment of suicidal and homicidal ideation and psychotic symptoms, whether or not they are present.
- Be concise.

BOX 1.7

SAMPLE CASE WRITE-UP

IDENTIFYING DATA

A 24-year-old single unemployed man supported by Social Security Disability Insurance and living with his grandmother

CHIEF COMPLAINT

"I tried to commit suicide."

HISTORY OF THE PRESENT ILLNESS

The patient is currently being transferred to a psychiatric inpatient unit from the medical service following a suicide attempt requiring admission to the intensive care unit 1 week ago. For approximately 1 month prior to admission he had been feeling "depressed" and "paranoid," convinced that people on the street as well as his family wanted to hurt him. He also believed that people were moving their eyes in a particular way as they tried to look at him surreptitiously because they were afraid that he had hostile intentions toward them. The experience was "really, really scary" and he felt "alone," as he spent hours in his room "praying that the feeling would go away."

Over the course of the month he became increasingly frustrated with being ill and unable to work, and he began to have thoughts of wanting to be dead. He did not lose his appetite, but he had trouble sleeping, was fatigued, and didn't enjoy anything. He heard a voice outside of his head repeating his name and saying "hi." His psychiatrist increased the dose of his risperidone (an antipsychotic). The increased dose made him feel sedated, but otherwise didn't seem to help. On the day of his suicide attempt he began to hear a "satanic" voice telling him repeatedly "kill yourself." He took about 30 risperidone pills as well as a handful of lithium. His grandmother came home earlier than expected and called 911 when she watched him faint as he tried to stand up. He told the emergency medical technicians that he had only taken health food supplements, hoping to avoid being taken to the hospital so that he would be left at home to die. After checking his blood pressure and pulse they insisted that he be taken to the hospital. In the emergency room he suffered a cardiac arrest and was in a coma for 3 days.

The patient reports that he had been thinking about his mother in the days leading up to his suicide attempt, as it was recently the 10-year anniversary of her apparently accidental death by heroin overdose. He also reports that he had tried to return to work about 6 weeks ago as a part-time outdoor messenger. He had been hoping that he was ready to go back to work, but felt extremely "stressed" within a couple of days and quit within 2 weeks, becoming preoccupied with the many losses that he has suffered, "jobs, the army reserve, my mind."

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PAST PSYCHIATRIC HISTORY

The patient first developed psychiatric problems 5 years ago. At that time he began regular attendance at a church and believed that the pastor "was God. I had thoughts that I was Jesus Christ. When the pastor preached, I felt like I was supposed to go tell others." He also became convinced that a well-known national political figure was "the anti-Christ." He dressed up in army fatigues and camouflaged his face in order to "go on a mission. I was supposed to kill him." He was picked up by the police and admitted to a psychiatric facility. He did not hear voices at that time. He was treated with risperidone and discharged after about 2 weeks. Since then he has had two additional psychiatric admissions. His previous admissions have been associated with medication nonadherence, as he has tended to discontinue his medications after a period of feeling better. The patient reports experiencing several "high" periods characterized by "super energy" and racing thoughts. He has also been "depressed" at times but he denies previous suicide attempts or significant suicidal ideation. He is somewhat unclear about the details and the precise time course of his mood symptoms. He has been taking lithium for the past year.

PAST MEDICAL HISTORY

The patient denies any significant medical problems or prior hospitalizations. He denies a history of head trauma.

CURRENT MEDICATIONS

Risperidone 6 mg/d, lithium carbonate 1200 mg/d

REVIEW OF SYSTEMS

The patient denies other psychiatric symptoms.

PSYCHOSOCIAL HISTORY

The patient was raised by his grandmother, who immigrated to the United States from the Dominican Republic as a young adult. He describes her as a warm, supportive, and noncritical person. His mother stayed with them, off and on, until her death. His parents were not married and he met his father only once, when he was 16 years old. He does not know where his father is. He has two younger half-brothers, 12 and 18 years old, who each have a different father. He denied a history of sexual or physical abuse.

The patient joined the army at age 17 years and completed 2 years of service. He did not see active duty. He earned his GED while in the army. He worked as a waiter and remained in the army reserve when he returned home. He was discharged from the army reserve at the time of his first psychiatric hospitalization. Since that time he has had a series of short-term jobs (cashier, messenger) but has been unable to work for more than a week or two. He reports some experimentation with marijuana, cocaine, and alcohol during early adolescence and while in the army, but denies recreational drug or alcohol use in the past few years. He has never had a

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romantic relationship, and he has become increasingly socially isolated over the past few years, aware that many previous friends from his neighborhood avoid him since he's had a mental illness. He has made some friends in his church, which he attends regularly and finds a comfort.

FAMILY HISTORY

The patient reports that his mother had "the same illness," which began after she started using drugs, and she had a long-standing addiction to heroin. His maternal grandfather had the "same illness" as well, and was an alcoholic. The patient is not aware of a history of psychiatric illness in other family members. His younger brothers are currently in school and apparently doing well.

PHYSICAL EXAMINATION

Within normal limits

MENTAL STATUS EXAMINATION

Appearance, Behavior, Speech, and Attitude

The patient is a young man with neatly styled, curly hair, who makes good eye contact and is cooperative with the interviewer. He has a somewhat wide-eyed, blank, unchanging expression on his face and blinks infrequently. His casual shirt is clean and neat. The patient sits quietly in his seat, rarely shifting position. He occasionally uses his hands to emphasize a point. His speech is clear, at times slightly fast, but remains in a monotone throughout the interview.

Mood

"Good, happy to be alive."

Affect

Blunted

Thought Process

Coherent and goal-directed, without loosening of associations

Thought Content

Denies paranoid delusions; "happy to be alive" after suicide attempt; denies[1] current suicidal ideation; no evidence of[2] homicidal ideation but not specifically asked[3]

Perception

Denies hallucinations

Cognitive

Oriented × 3; short-term memory good (3/3 objects in 2 minutes); long-term memory appears good, though dates need to be corroborated; fund of knowledge good (knows current president and recent news events); simple calculations with money correct; difficulty with serial sevens; serial threes slow, with mistakes that the patient immediately caught and corrected

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Insight

Patient appears to have an excellent understanding of having a "mental illness" that has profoundly affected his life: "I've lost so much." Spontaneously explains that beliefs about people wanting to hurt him and the conviction that he was Jesus Christ were "crazy."

Judgment

Patient appears to be cooperative with his treatment. He feels that his "attitude" is better now in that he understands the need to take his medication. He realizes that he came very close to dying and is relieved that he did not die.

LABORATORY RESULTS

Most recent labs, including creatinine, blood urea nitrogen (BUN), and electrolytes, were within normal limits. Urine toxicology screen at the time of admission was negative for recreational drugs including marijuana, cocaine, and opiates. Brain MRI shows moderate cortical atrophy, including enlarged ventricles; no focal findings.

CASE SUMMARY

The patient is a 24-year-old man with a 5-year history of intermittent psychotic and mood symptoms who was admitted 1 week ago after making a serious suicide attempt in response to command auditory hallucinations. His medical condition is now stable. His mental status examination is notable for blunted affect. The patient no longer appears to be psychotic, and he denies current suicidal ideation.

DIFFERENTIAL DIAGNOSIS

The patient's psychotic symptoms (auditory hallucinations, paranoid and grandiose delusions), blunted affect, and functional deterioration are most suggestive of chronic schizophrenia. His mood symptoms (both depression and mania) suggest the possibility of schizoaffective disorder, most recent episode depressed, although overall it is not clear how predominant those symptoms are in relation to his psychotic symptoms (see Chapter 4, Schizophrenia and Other Psychotic Disorders). A mood disorder with psychotic features seems unlikely as he has been psychotic without mood symptoms (e.g., at the time of his first hospitalization). A substance-related psychotic disorder seems unlikely given his recent abstinence (confirmed by his negative toxicology screen on admission). There is no evidence of another medical cause for his symptoms, and his MRI scan is consistent with chronic schizophrenia (see Chapter 4, Schizophrenia and Other Psychotic Disorders).

Diagnosis: Chronic schizophrenia versus schizoaffective disorder; status post suicide attempt, medical sequelae resolved

PREDISPOSING AND PRECIPITATING FACTORS

Biological Factors

A genetic predisposition seems likely, given his family history. Drug use may have played a role in precipitating his first psychotic episode. Medication nonadherence may be contributing to his recurring symptoms.

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Psychological Factors

The patient was raised by a loving caregiver, but his childhood was nonetheless marked by deprivation and trauma, as his father was absent and his mother was probably emotionally unavailable to him given her own psychiatric and substance abuse problems, culminating in her unexpected and traumatic death during his adolescence. Recent stressors include the anniversary of his mother's death, and his growing realization that he may never be able to work.

Social Factors

The patient has been struggling with acceptance of his chronic mental illness, which has isolated him to some extent from his family and friends, in part as a direct result of the illness, but also probably due to social stigma.

TREATMENT PLAN

It will be useful to obtain additional information from his treating psychiatrist and his grandmother, as well as records from his previous psychiatric admissions, in order to define better the extent and timing of his mood symptoms in relation to his psychotic symptoms and overall illness course. He may not require a long hospitalization if he remains asymptomatic, and the psychosocial aspects of the treatment plan outlined below may be conducted on an outpatient basis. The role of the hospital staff would be to locate appropriate programs and facilitate the patient's initial referral and connection to them.

Biological Treatment

It may be time to consider a change to new antipsychotic and/or mood-stabilizing medications, given his recent exacerbation. The decision may be informed by further clarifying his degree of medication nonadherence, since his psychotic symptoms are now resolved on the same medications that he was taking prior to admission. A long-acting injectable antipsychotic may help address the nonadherence issue.

Psychological Treatment

Group psychotherapy with other patients with chronic mental illness may be helpful, if he can feel comfortable in a group setting, in order to provide ongoing psychoeducation and support in his struggle to accept the realistic limitations of his likely chronic psychiatric disorder (see Psychosocial Treatment in Chapter 4, Schizophrenia and Other Psychotic Disorders). Supportive psychotherapy on an individual basis may help him to develop better coping skills and, in a carefully modulated manner, better awareness of and control over the continued impact of his childhood marked by deprivation and loss.

Social Treatment

Given his growing demoralization in the face of his apparent inability to work, participation in a day program may be useful to provide a more structured and

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supportive setting in which to try to be productive. A day program would also help to mitigate his social isolation.

PROGNOSIS

Fair. The patient currently appears to have good insight and judgment, but his repeated episodes of medication nonadherence are of concern, as are his strong family history and recurrent psychotic episodes. The fact that he acted in response to command auditory hallucinations to make a nearly fatal suicide attempt is extremely concerning.

The presence of mood symptoms and the possibility of a diagnosis of schizoaffective disorder are better prognostic indicators, as is the consistent presence in his life of his supportive grandmother (her age and health should be inquired about, as he will be at high risk for decompensation when her health deteriorates).

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[1] "denies" implies that the patient has been specifically and directly asked about the symptom.

[2] "no evidence of" implies that the interviewer did not observe the symptom, but did not specifically inquire about it.

[3] "not specifically asked" should be stated explicitly if the presence or absence of a symptom is of particular importance, as it is in this case.

Laboratory Tests

Blood and urine tests are frequently crucial adjunctive data to a thorough history in ruling out other medical conditions as possible causes of psychiatric symptoms as well as in identifying unrelated medical illnesses requiring treatment. In addition to the standard chemistry and hematological panels, toxicology screening should always be considered to rule out substance-induced disorders (see Chapter 7, Substance-Related and Addictive Disorders). Specialized blood tests and other modalities such as computerized tomography (CT) scanning, magnetic resonance imaging (MRI), and electroencephalography (EEG) can be used to screen for possible causes of delirium (e.g., fever, metabolic abnormalities) or neurological conditions with behavioral manifestations that could be mistaken for a psychiatric disorder (e.g., a patient with a brain tumor located in the frontal lobes might present with symptoms of a mood disorder). A neuropsychological battery of tests can sometimes be useful. All testing should be done with an eye toward balancing costs (both economic costs and health risks to the patient) with possible benefits. This judgment is based on a realistic estimate of the probability of a particular condition given its prevalence and the patient's presentation (see chapters on individual disorders, particularly Chapter 5, Neurocognitive Disorders and Mental Disorders Due to Another Medical Condition, for specific indications).

IMPRESSIONS

Once the physician has obtained the history and made his or her observations, further integration and planning remains. The physician's impressions of the patient and the patient's symptoms can be organized into three discrete sections that build on one

another: (1) the case summary, (2) the differential diagnosis, and (3) predisposing and precipitating factors.

Case Summary

While the history presents the facts in such a way that readers can make their own judgments as to the validity of the interviewer's conclusions, the case summary begins the process of integration. The case summary remains descriptive, but it is more tightly focused and analytical than the patient-focused perspective of the history and the purely observational tone of the mental status examination. As the example in Box 1.7 illustrates, the case summary is mercilessly brief and succinct. Yet it is an important step toward identifying those findings in a particular patient that are similar to those found in other patients (i.e., toward making a diagnosis).

It is also a step toward completing other aspects of the overall assessment that can be at least as important as the diagnosis: Is the patient a danger to himself or herself, or to others? Will the patient be adherent to medication and other treatment recommendations? Thus, the case summary may include statements about the patient's **current level of functioning** and **behavior patterns,** as well as assessments of particular **symptom patterns** and **risks**. For example, the physician might conclude that a patient is **psychotic** (i.e., reality testing is impaired, as indicated by the presence of delusions, hallucinations, or a thought disorder, as described in Chapter 4, Schizophrenia and Other Psychotic Disorders). The term *psychotic* is at a level of overall assessment that does not belong in the mental status examination itself but should be included in the case summary as the physician begins to reach conclusions. Similarly, while the patient's thoughts, fantasies, and plans regarding suicide are recorded in the mental status examination, the physician's impression of the patient's impulse control and **suicide risk** should be included, when relevant, in the case summary.

Differential Diagnosis

The diagnosis summarizes patterns of data, predicts the course of an illness and the recovery from it, and suggests treatment options. In the systematic process of case formulation, the diagnosis is a separate step that is reached only after the patient's psychopathology has been summarized descriptively. Following this sequence keeps physicians disciplined and helps them consider all appropriate diagnoses systematically. This sequence does not mean that physicians are not thinking about diagnoses until this point. On the contrary, diagnostic possibilities are being entertained, patterns are being sought, and hypotheses considered and discarded all the while the physician is gathering data and making observations. By the time the physician begins to create the written record, the most likely diagnoses should have been identified. The entire case write-up is organized with those diagnoses in mind. However, following the formal sequence of steps (i.e., first, the history and observations; next, the summary of the psychopathology and other findings; and, finally, the diagnostic impressions) ensures that each section does indeed follow logically from the previous one.

Identifying specific diagnoses should be relatively simple after the psychopathology has been carefully described. The first question to answer is which **general category of psychopathology** does the patient's symptoms fit into, based on the history of the present illness and the mental status examination. These categories include the mood, psychotic, cognitive, anxiety, and personality disorders. Once the general category is determined,

more specific details must be considered. This is where knowledge of characteristic diagnostic and prevalence patterns, including **gender and age differences**, is most crucial.

For example, a 19-year-old with no prior psychiatric history presented with auditory hallucinations and grandiose delusions, which had been occurring for six months. Because of the frequent onset of schizophrenia during adolescence, this disorder quickly became the most likely diagnosis, based on this brief piece of history. Substance-induced psychotic episode and bipolar disorder would be two other possibilities in the differential diagnosis. A 35-year-old woman with the same presentation is much more likely to be suffering from a mood disorder with a manic episode or mixed features, while a 65-year-old woman would be given a diagnosis of psychiatric disorder due to a another medical condition until this was proved otherwise. A closer look at more details about the patient's condition will either confirm the initial diagnosis or suggest other, less obvious diagnoses.

The degree of certainty regarding the diagnosis depends in part on the amount of detailed historical information available. A brief initial evaluation interview will probably generate a long list of possible differential diagnoses, whereas a formulation composed at the end of a lengthy hospital stay should present a fairly definite diagnostic impression.

Predisposing and Precipitating Factors

The formulation is not complete even after a diagnosis has been reached. The diagnosis reflects only those signs and symptoms that the patient shares with other patients who have the same disorder. Assigning a diagnostic label identifies common features but tends to blur the more subtle, and not so subtle, distinctions among individual patients with the same diagnosis. While this diagnostic labeling is crucial for purposes of communicating with others involved with the patient's care and for beginning to establish a prognosis and develop a treatment plan, it is not sufficient for describing an individual person who is suffering from an illness. The **biopsychosocial approach** describes the **patient's strengths and vulnerabilities** and helps to convey the patient's uniqueness. Vulnerabilities can also be labeled as possible predisposing or precipitating factors. In recent years, the biopsychosocial approach has been expanded to include a **cultural formulation**, which considers the patient's symptoms, stressors, supports, vulnerability, and resilience in relation to his or her cultural reference group. The case formulation in Box 1.7 illustrates the three parts of the clinical impressions, based on the history and findings.

TREATMENT PLAN

Having completed a careful description of the patient's problems, their possible origins, and the patient's capacity to deal with those problems, the physician is finally ready to formulate a treatment plan. Immediate and long-term goals and concomitant recommendations for treatment should be delineated. The **patient's goals** must be given prime importance as the treatment plan is being developed. The recommendations should include not only the ideal treatments but also those that are feasible given the patient's resources. Frequently, an initial step in the treatment plan will be obtaining additional information, such as history from family members and records of prior treatment.

The **biopsychosocial perspective** is useful in treatment planning because it focuses on all aspects of the patient's problems and their solutions. **Biological factors** might be treated with medication, electroconvulsive therapy, hypnosis, or bright-light phototherapy; **psychological factors** with various forms of psychotherapy; and **social factors** with

hospitalization or other environmental changes, such as mobilizing a wider friendship network, joining a self-help group such as Alcoholics Anonymous, or obtaining additional work skills (see sample treatment plan in Box 1.7).

PROGNOSIS

The prognosis is a prediction of the course an illness will take (i.e., it is the physician's educated guess as to how a particular illness will play itself out in a particular patient). This prediction is based on the physician's specific knowledge of the individual patient and general knowledge of diseases (e.g., a depressive episode tends to resolve with adequate psychopharmacological and psychotherapeutic treatment, whereas schizophrenia tends to be characterized by years of waxing and waning symptoms and progressive impairment). In other words, given the diagnosis, as well as the patient's strengths and vulnerabilities, to what extent will he or she recover and perhaps even achieve better personal adjustment? The sample case formulation in Box 1.7 concludes with the patient's prognosis.

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/// 2 /// The Psychiatric Interview

ANAND DESAI AND LYLE ROSNICK

The psychiatric interview is the physician's most important tool for arriving at a diagnostic and prognostic assessment as well as formulating a treatment plan. It can be thought of as a clinical procedure, deployed for both diagnostic and therapeutic purposes. When the interview is conducted in a supportive and empathic manner, the very act of the physician's seeking information from the patient should alleviate the patient's suffering. Just as mastery of a procedure for the surgeon requires years of study, repetition, supervised practice, and thoughtful review, it can take years to acquire proficiency and a sense of confidence as a psychiatric interviewer. Nonetheless, even a novice can learn to conduct competent, thorough, and therapeutic evaluations.

GENERAL PRINCIPLES

Psychiatric and other types of medical interviews share certain similarities. Both types of interviews include the patient's subjective account of symptoms and the physician's more objective assessment of the patient's thoughts, feelings, appearance, and behavior. The physician begins both types of interviews by considering the patient's chief complaint, that is, what caused the patient to seek help at that point in time. In both types the patient is asked about the present illness and the past history. The psychiatric interview includes a survey of the major realms of psychopathology, which is analogous to the review of systems in other medical evaluations. In addition, the psychiatric interviewer is interested not only in the patient's illness and the ways that the patient experiences and copes with it but also with his or her social, academic, and vocational functioning in general, past and present.

Within the conceptual framework of the medical model, psychiatric symptoms are seen as direct manifestations of an illness, just as chest pain is seen as a possible symptom of coronary artery disease. The interviewer notes the presence or absence of symptoms of pertinent illnesses or syndromes, tracks the course of symptoms, and looks for factors that exacerbate or alleviate them, including previous treatment. Panic disorder, obsessive-compulsive disorder, and major depression lend themselves particularly well to the medical model.

While adhering to the basic medical model, the psychiatric interview has four additional essential and distinguishing features: a psychological perspective, empathic

BOX 2.1

GENERAL INTERVIEWING GUIDELINES

- Maintain a professional stance that is empathic, respectful, and curious.
- Begin with open-ended questions.
- Follow up with focused questions.
- Avoid technical terms.
- Make use of silence.
- Provide periodic summaries.
- Ask for clarification.
- Attend to emotional responses.
- Empathize without offering false reassurance.

listening, particular attention to the physician's emotional responses, and a focus on the interview process (see Box 2.1 for general interviewing guidelines).

Psychological Perspective

To do justice to the complexity of psychiatric illnesses and patients, the physician must employ working models of the mind, in addition to neurobiological models of brain dysfunction. The psychodynamic model is a psychological perspective that views unconscious thoughts and feelings as powerful motivators and inhibitors of behavior. Symptoms are understood not simply as manifestations of brain chemistry but also as reflections of underlying psychological processes, including psychologically determined solutions to problems and conflicts that the patient may not be consciously aware of. From the standpoint of this perspective, the patient's recurring patterns of behavior in significant interpersonal relationships, past and present, are especially relevant. They represent potential clues to how the patient will experience and relate to the interviewer and to subsequent caretakers. The patient's internal psychological conflicts, management of strong affect, and capacity for gratification in love and work are also of primary interest (see sample interview in Box 2.2).

Other psychological, behavioral, and social scientific theories are widely employed by contemporary psychiatrists as well. In addition to the psychodynamic perspective, cognitive, behavioral, and interpersonal theory can be relevant for the assessment and treatment of patients with specific psychiatric disorders. Each theoretical perspective opens up ways of listening to patients, making sense of clinical encounters, and structuring treatments. Theoretical perspectives, or models of the mind, are not mutually exclusive; the psychiatric interviewer views them as complementary and variably useful, depending on the patient, the psychopathology, and the situation.

Empathic Listening

Because psychiatric problems are primarily experienced in the mind, the patient's subjective experience is of paramount importance. Empathic listening involves actively trying to see the world through the patient's eyes. Empathy requires imagination. Imagining a paranoid patient's sense of danger and isolation, for example, or an anxious patient's sense of imminent catastrophe, helps the physician capture the inner world of the patient.

BOX 2.2

INTERVIEW EXAMPLE DEMONSTRATING USEFULNESS OF A PSYCHOLOGICAL PERSPECTIVE

A 31-year-old female bisexual Hispanic graduate student was admitted to the hospital for treatment of a major depressive episode following the death of her mother. She has been in the hospital for 5 days. The female physician interviewer just rotated onto the service and is meeting the patient for the first time.

Interviewer: Can you tell me about the circumstances that led to your hospitalization?

Patient: I'm really not in the mood. They told me this morning that you would be my doctor. I could tell I wasn't going to feel comfortable talking to you. You look younger than I am! [The physician was indeed 3 years younger than the patient. The interviewer did not know quite how to respond. The patient got a bit angrier and looked the physician up and down. The interviewer was tense but remained composed.] You don't look like you can handle me. And I get this feeling that you're too confident, cold and clinical. Very straight. Too straight and middle class. You look perfect, with your outfit and your hair.

I: I see. Well, where do we go from here? You've given up before you've even started.

P: Oh, I have started. Listen, I'm sorry, but I really just can't see you treating me. How do I get assigned another doctor?

I: I don't know, I think you'd have to talk to the director of the unit.

P: Maybe I can be assigned to the other doctor. She looks like she speaks Spanish.

I: Would you be more comfortable speaking Spanish?

P: [The patient snapped angrily.] What the hell do you think?

I: OK, I'm sorry. Let me talk to my director, and I'll get back to you.

In this vignette, the interviewer is faced with a difficult and serious challenge. The patient is overtly hostile and contemptuous, making hurtful and personal attacks, rejecting wholesale the physician as a person as well as anything that she might have to offer. Such situations can be decentering and demoralizing; they can stir up strong feelings toward the patient that impact the present moment as well as the course of ensuing treatment. Conceptualizing what has gone wrong can inform an attempt to salvage the interview and the treatment.

Because the patient has refused to engage in the interview, the physician has correctly chosen to focus on the impasse, although the intervention might have gotten more traction if she had referred specifically to their relationship (changes italicized): "You've given up *on me* before *we've* even started." When the patient redoubled her rejection, the physician remained composed and professional, assessing whether the patient was concerned about a language barrier. The patient snapped back in a dramatically disrespectful manner. Understandably, the interviewer felt taken aback by the attack, and helpless to connect with the patient.

The physician's sense of defeat is in part realistic: there can be no productive interview until the patient's anger is addressed. The patient's behavior and affect may

(continued)

in part constitute rage and irritability due to a mood episode, personality disorder, substance-related disorder, medication side effect, or other underlying process. The evaluation that is necessary to make that determination cannot proceed because the patient's response to the physician has ground the interview to a halt. How can the physician understand and manage this stalemate?

First, the physician must register that the patient has very concretely transferred onto the physician a whole set of assumptions, beliefs, and motivations that belong to the patient's internal world. The patient is displaying an intense emotional and psychological response to the physician, despite not knowing her. Keeping in mind that this response reflects the patient's psychology, and is virtually unrelated to the physician, can help the interviewer to feel less personally affected, rejected, offended, or emotionally reactive. Separating the patient's fantasies from reality will help the interviewer to gain some distance from and perspective on the patient's distortions so that they can be named, thought about, discussed, and understood. The interviewer may then be able to call to mind what little she knows about the patient—for example, that her mother has died and her most recent physician has rotated off service. This information could lead the interviewer to hypothesize that the patient might be feeling abandoned, helpless, and angry, as well as terrified about getting close to and losing another caretaking figure, with all the pain that can entail. This understanding can help the interviewer begin to find seeds of empathy for the patient. Maintaining an attitude of unwavering respect and engaged curiosity, and taking a nondefensive and nonjudgmental approach, the interviewer could then make any one of the interventions listed below that felt most comfortable. Interventions such as these will elaborate more of the patient's inner world and put into words impulses, feelings, and fantasies that the patient is otherwise enacting, thus paving the way for the beginning of a collaborative interview and doctor–patient relationship.

"I can assure you I'm not perfect, but tell me more about why you're so sure I can't help you based only on my appearance."

"You obviously doubt that someone like me can help you."

"You're having a very strong reaction to me, and I'd like to understand it more. What else have you noticed about me to convince you I'm of no use?"

"It sounds like I really seem quite young and incompetent to you right now. And very straight. What kinds of experiences have you had with people who are similar to the way you see me?"

"How do you see me as straight?"

"How do you see yourself as a lot to handle?"

"What were the first things you noticed, when you knew you weren't going to feel comfortable talking to me? It sounds like an awful feeling for you to have."

"It's as if, in your mind, there's an image of me as a detached and uppity doctor, very different from you, almost too different to understand and relate to you in a helpful way."

Patients who feel that the interviewer wants to and can understand their perspective are far more likely to cooperate meaningfully with the interview. The physician's communication of understanding often helps the patient feel less confused, helpless, or alone. This, in turn, may help patients feel better about themselves, crucially mitigating feelings of guilt, humiliation, or shame. The patient's experience of feeling understood, together with the physician's emotional experience of coming to empathic understanding and making empathic contact, constitutes the bedrock of the **therapeutic alliance**. In the process of sharing their suffering with the physician, patients may experience a measure of relief. The interviewer who encounters the patient once only can still effect a truly therapeutic interaction.

Listening to the patient's **verbal communication** involves hearing more than the explicit meaning of the words. The physician tries to register the music of the language. All elements of language, including figures of speech and tonal modulation, convey emotions and contribute to the depth and meaning of verbal communication. Likewise, the interviewer should be attuned to other implicit aspects of the patient's speech—such as the ease or difficulty of following the story; the order in which it is told; omissions, hesitations, contradictions; as well as the congruence or lack thereof between what is being said and how the patient says it. The physician also listens to the patient's **nonverbal communication**, or body language, which includes facial expressions, gestures, and posture.

Physician Emotional Responses

In addition to verbal and nonverbal communication, the psychiatric interviewer tunes in to a third channel of communication: his or her own emotional responses to the patient. The physician who is authentically involved in the interview—listening, imagining, trying to empathize—is bound to have emotional responses in the process. Indeed, the absence of any emotional response in the physician, or a general emotional blandness coming through on this channel, is itself a significant deviation from the expectable and, as such, should prompt reflection and further investigation. There are numerous potential barriers to the physician's ability to make an emotional connection with a patient. Barriers may stem from the patient, the interviewer, or their mutual interaction. Before arriving at any conclusions, the interviewer needs to subject his or her own emotional responses to critical inquiry: Am I having a personal, idiosyncratic response to this patient? Am I feeling something that the patient is having trouble acknowledging? Is it possible that the patient is inducing these feelings in me, and if so, how and why might the patient communicate with me in this way? The physician's awareness of his or her emotional responses to the patient can inform interventions even at the outset of the interview, as the example in Box 2.3 illustrates. The importance of formulating answers to these questions will vary according to the patient's psychopathology, the clinical setting, and the purpose of the interview. The interviewer sometimes integrates this channel of information into the clinical picture only *after* completing the interview. As one eminent psychiatric interviewer framed the charge: "To see into the mind of another we must repeatedly immerse ourselves in the flood of his associations and feelings; we must be ourselves the instrument that sounds him" (Nemiah 1961). Thus, in the psychiatric interview, the physician makes use of his or her whole self as an instrument of healing, a complex and rewarding challenge.

Attention to Process

The psychiatric interview differs from other medical interviews in its emphasis on observing, and then examining, both the content and **process** of the interview as interrelated

BOX 2.3

INTERVIEW EXAMPLE DEMONSTRATING USEFULNESS OF ATTENTION TO THE PHYSICIAN'S EMOTIONAL RESPONSE

Interviewer: What brought you to the hospital today?

Patient (32-year-old woman): Well, my daughter died last winter, and she would have been 6 years old next week, and I began having flashbacks to an incident that occurred at my neighbor's during my childhood. This morning I was having that flashback. I felt as if I were almost reliving the experience and becoming a little girl! [The patient is visibly distraught and on the verge of tears.]

I: Did the memory come after that?

P: I can't remember when I first remembered it.

I: Did your daughter's upcoming birthday stir up these thoughts?

P: I don't know.

The interviewer began with a classic open-ended question. In response, the patient provided an emotion-laden answer, a confusing hodgepodge about two subjects (i.e., thoughts of her daughter and flashbacks of traumatic memories from her own childhood). Her manner of speaking was difficult to follow, disorganized, impressionistic, and bereft of details. It is logical that the interviewer would have been puzzled and would have wanted to make sense of her initial reply. However, he prematurely adopted a line of questioning that closed off the discussion. The physician tried to fill in the gaps himself by asking a number of unrelated, closed-ended questions, rather than by requesting her to clarify and elaborate on her own on what she already had said. If she had been unable or unwilling to do so, the interviewer might speculate that the nature and intensity of her feelings (and perhaps her fear of being overwhelmed by them) were preventing her from thinking and expressing herself clearly. It would have been more empathic and productive for the physician to show an interest in what the patient was feeling, for example, by saying, "What a terrible loss. You must be feeling overwhelmed." In fact, the interviewer himself was feeling horrified and threatened by the patient's tragic story. He thus was afraid to invite her to share her feelings with him. Because of his inability to contain his own anxiety and to process his other emotions, he was unable to tolerate a deeper exploration of her emotional state. Instead, he chose to sidestep her feelings by reverting to who, what, when, where, and why questions, as a journalist would.

manifestations of the patient's pathology. The process of the interview refers to how the patient communicates and engages with the interviewer, as well as to the type of interaction and rapport that emerges. The physician must create an environment in which a meaningful and informative process can develop. To do this, the physician needs to assume and maintain an attitude of unconditional respect for and interest in the patient. As the interview gets underway, the physician is prepared to listen actively without judgment, neither relinquishing nor seizing control. He or she strives to maintain a state of

mind that allows for emotional receptivity and emotional contact with the patient, following the story as it is told. Not every moment of confusion needs to be addressed, as it may be a transient issue that the patient will soon clarify. Remaining curious, engaged, and connected, the clinician can contain the patient's emotions and distress simply by listening. The physician's skill in transiently tolerating confusion and discomfort allows the patient some freedom to think, feel, and speak in his or her own way. The interviewer can promptly intervene if the patient proceeds in a grossly disorganized manner, whether due to psychosis or another underlying deficit in thought, language, or memory. In most situations, however, the psychiatric interviewer is prepared to listen actively, completely focused on the patient and the interview process. The interview will be most informative and, therefore, helpful to both participants if the process is not initially dominated by the physician but rather allowed to emerge from the patient, telling his or her story in his or her own way.

The psychiatric interviewer is often silent, listening attentively. For the psychiatric interview to be most productive, the patient requires time to respond to the interviewer's questions spontaneously and at length. To facilitate this process, the physician can use brief, nondirective interventions. These are relatively neutral phrases or questions. For example, the interviewer may repeat or restate the last thing the patient said before falling silent. At other times, the physician might simply make an observation about the process itself: "You are tearful" or "You stopped yourself." With a hesitant or disengaged patient, the interviewer might ask whether something is making it difficult to talk. Simple, intuitive responses and questions similarly maintain a connection with the patient and his or her story without undue impingement. For example, an "Uh huh," "What happened then?" or "Tell me more about that" can facilitate the flow of the interview in a nondirective manner. The example in Box 2.4 illustrates two basic principles related to interview process: (1) when experiencing strong feelings during an interview, the patient will stonewall the physician unless he or she is given an opportunity to express these emotions, and (2) when a significant impediment to the progress of the interview manifests itself, it must be addressed if the interview is to proceed productively.

CONDUCTING THE INTERVIEW

Preparatory Phase

Setting the Frame

The interviewer greeting a new patient should provide straightforward introductions, aiming for a relatively natural and professionally warm demeanor. Adult patients should be addressed formally by their last names, and the interviewer can follow the patient's lead with regard to shaking hands. The physician then provides a clear statement about the capacity in which he or she will be relating to the patient, as well as expectations of the patient and goals for the interview. If the physician knows something about the patient, this should be addressed by saying something such as, "I understand that you were brought to the emergency room in an ambulance, and I've had a chance to speak with your outpatient doctor briefly. But I am most interested to hear from you directly what has been going, what led to your coming in today, and where you are with all of this now."

From the very beginning of every psychiatric interview, it is crucial to treat the patient as an active collaborator rather than as a passive subject. It is often helpful to explain to the patient how he or she can function to make the interview most useful. The informed

BOX 2.4

INTERVIEW EXAMPLE DEMONSTRATING THE IMPORTANCE OF EARLY PROCESS OBSERVATIONS

Interviewer: What brought you in today? [Silence.] Could you tell me a little bit about yourself? How old are you?

Female Patient: Nineteen years old. [Silence.]

I: And you live where?

P: Connecticut. [Silence.]

I: Whom do you live with?

P: My mom and my sister. And my three cats.

I: And your father?

P: He lives in Alabama.

I: Oh, I see. Your parents . . . are . . . divorced then?

P: Yes.

I: I see. How long have they been divorced?

P: About 4 years.

I: And what do you do?

P: I just finished my freshman year of college.

I: How was that?

P: Fine.

I: So you are home for the summer and go back in the fall?

P: Yes.

The physician began with an **open-ended question**: "What brought you in today?" In response to the patient's silence, the interviewer changed the subject and asked two questions in rapid sequence. When the patient chose to respond with her age, the interview took the form of a series of **closed-ended questions** that required brief, factual answers. The physician sought exclusively demographic information about the patient and her relatives. It is understandable that the physician wanted to know something about the details of the patient's life. Perhaps this interviewer initially felt more comfortable asking questions with predictable, unemotional answers. The early interview process deteriorated into one in which the patient compliantly provided brief answers to numerous "survey" questions. The interview had taken on a ping-pong quality. Too many closed-ended initial questions, not altogether uninformative, miss the mark in terms of establishing an effective psychiatric interview. They inhibit patients from sharing or even learning about their inner, subjective experience as well as what is most important to *them* at the moment.

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Eventually realizing what had happened, the physician switched gears by returning to an open-ended question about the chief complaint:

I: So how can I be of help to you?

P: I'm not sure right now. [Silence.] You know, I've been on the waiting list for 6 months.

I: You want to tell me about that?

P: I don't know, maybe you can tell me! Six months is a mighty long time.

I: It certainly is! And you clearly have a lot of feelings about it. Please tell me about them.

In actuality the patient did not even answer the question about what initially led her to call for an appointment. Nevertheless, the question and the reply represented a turning point in the interview. At that juncture the interview and the patient came to life. The patient accepted the invitation to open up by sharing her most pressing feelings. It was as if the patient (accurately) interpreted the open-ended question as a signal that the interviewer was now willing and able to let her talk and have some control over the topics discussed. The physician immediately realized that the patient had let him in on her feelings toward the clinic (and, by extension, toward the interviewer himself). The interviewer responded empathically, and wisely asked the patient to elaborate. With this intervention the physician took another giant step toward establishing a therapeutic alliance by explicitly manifesting interest in the patient's emotions. After expressing her frustration, the patient naturally segued into a discussion of her situation.

patient will feel more secure and confident about how to proceed. To develop and maintain a therapeutic alliance, the interviewer should strive to be thoughtful and empathic during every interaction with the patient. Respect and consideration of the patient's needs and concerns should be shown even before the interview begins. Informing the patient in advance of the interview's purpose and duration, and whether it will be the only meeting or the first of many, will begin to establish a **frame**, which is the mutually agreed upon basic structure of the treatment. The frame also includes the location, frequency, and cost of sessions, if applicable.

The process of establishing the frame will vary depending on the setting. *In the emergency room*, for example, the physician may explain as follows: "You and I will talk for 30 minutes now, and I will be here through the night. My primary goal at the moment is to understand in as much detail as possible what led to your coming to the ER and how you are feeling now. From time to time I may interrupt you, because there is a lot I'd like to learn about you and your situation in the limited time we have. After we speak, I'll be reviewing your records, including the blood work and imaging; I'll discuss the situation with the team and come back to figure out with you what's next. Let's begin with what brought you to the ER today." *In the outpatient setting*, the interviewer might say: "Today's evaluation will last for an hour. I will review your records in the coming days and give you a call next week to discuss my impressions with you." *On an inpatient unit*, the physician can let the patient know that they will meet daily for half-hour sessions.

The Interview Setting

Physicians in clinics, emergency rooms, and inpatient units often have little control over the setting of the psychiatric interview. The place available for an interview is likely to be a sparsely furnished, windowless room or even a hallway. Regardless of the locale, the interviewer should arrange the environment as much as possible so that there is privacy and freedom from intrusion, as well as a reasonably comfortable place for both interviewer and patient to sit. Unneeded distractions, or the potential for intrusions, impair the interviewer's ability to be fully present, actively and empathically listening, emotionally available, and receptive. If the setting permits, the interviewer may even ask if the patient is satisfied with the room temperature, inviting input into whether a window should be opened or the air conditioner turned off.

Safety

Both interviewer and patient need to feel emotionally and physically secure. A frightened, preoccupied interviewer cannot conduct a successful interview, and a fearful, distracted patient cannot do his or her part. Certain measures can be taken if either person is frightened. For example, the presence of a security guard in the room might make a paranoid patient feel more comfortable. The interviewer of a potentially assaultive patient might choose to conduct the interview in a patient lounge or waiting room: participants can sit farther apart so as not to feel cornered, and guards or other staff members can be present at close range. The interviewer's fears should never be ignored, even if they seem irrational or exaggerated. Instead, the interviewer should seek advice and direction from someone with more knowledge and experience. Patients should be interviewed only under conditions in which everyone involved feels safe (see Chapter 13, Violence).

Language

Evaluation of the patient's verbal proficiency, when indicated, should be conducted at the beginning of the interview. The interviewer can ask: "What languages do you speak other than English? Which language are you most comfortable speaking?" Using an **experienced translator** with patients whose first language is not English is crucial for psychiatric interviews, which rely on observations of patients' thought patterns and on open discussion about the intimate details of their personal lives. Family members and friends are extremely unreliable as translators. In addition to the obvious fact that patients may feel inhibited about fully disclosing their symptoms and behaviors in the presence of a family member, other pitfalls abound. The family member may be reluctant to translate the interviewer's questions or the patient's responses accurately, particularly when they concern self-destructive thoughts or psychotic symptoms. The family member may also try to present the patient's responses as more organized and coherent than they actually are. These distortions may be conscious or unconscious. An inexperienced translator may make the same errors, but there is generally less motivation to do so.

It is possible to perform an empathic interview that is diagnostically and therapeutically useful despite the use of a translator. The following guidelines are helpful. The interviewer should make eye contact with the patient, not the translator, and the translator should sit off to the side. This arrangement will encourage the patient to focus on the physician. The physician should encourage the translator to maintain the give-and-take flow of the interview but to interrupt if necessary in order to explain areas of confusion or difficulties in fully conveying the patient's meaning. Interviewers should use their usual body language, including hand gestures, facial expressions, and vocal inflections.

History-Taking Phase

In most clinical situations, this phase should begin with an open-ended question, such as "How can I be of help to you?" "What brought you in today?" or "How did you come to be hospitalized?" Some patients require little further prompting to answer such questions in a coherent and detailed manner. When this happens, the interviewer should allow the patient to speak at some length and resist the temptation to interrupt. While listening actively and empathically, the physician can begin to observe such things as the patient's capacity for goal-directed thinking, as reflected in the coherence of the patient's story.

For patients who are able to give their recent history in a spontaneous and comprehensible fashion, the interviewer during this phase needs to employ techniques that encourage the patient to continue speaking. Eye contact, an occasional head-nod, and a succinct restatement of what has been said will let patients know that the physician is following their story. At times, the interviewer can respond with a relatively neutral, nondirective intervention, such as "What happened next?" or "How did you understand that?" or "How did you feel at that point?" The interviewer's goals during this relatively unstructured phase of the interview are to maintain a connection with the patient and to encourage elaboration of the story.

The more open-ended this initial phase of the interview remains, the greater the interviewer's chances of discerning potential clues, the further exploration of which may clarify whether the patient has a psychiatric disorder and, if so, in what broad realm(s) of psychopathology. Of particular relevance in this regard are the patient's report of any symptoms of distress; troubling feelings or ideas; changes in functioning; problems in interpersonal relationships; parts of the story which are particularly difficult to understand or imagine, potentially suggesting an area of psychological conflict; and potential stress due to life events or the patient's environment, taking into account the social and cultural context.

After listening at length, the interviewer follows up on the patient's chief complaint and present illness in a more systematic and structured manner, using specific, closed-ended questions to establish such details as the presence or absence of symptoms; the duration, course, and severity of symptoms; exacerbating or ameliorative factors; associated illnesses; and the patient's understanding of and responses to the symptoms. In effect, the physician begins by surveying the landscape, and then hones in on all areas of potential interest to investigate them in finer detail.

Challenges to History-Taking

Two relatively common scenarios require immediate intervention: the disorganized patient and the difficult-to-engage patient.

The Disorganized Patient

Patients who are in acute distress or actively disorganized are generally not able to communicate their problems effectively to the interviewer. Their difficulty will usually emerge soon after the interviewer's opening question. In these cases, the interviewer will need to impose structured questions earlier, both to contain the patient and to investigate the disorganization. The physician must attempt to clarify the cause of the patient's confusion. Is the patient cognitively impaired, for example, or psychotic, or intoxicated? The interview of the disorganized patient will more closely resemble a detailed mental status examination and a focused medical history. The physician might first establish whether there are cognitive deficits. Formal testing can be introduced by stating, "I have

the impression that you may be having difficulty with things like concentration and memory. I'd like to ask you some questions to clarify whether you're having difficulties in these areas" (see Chapter 5, Neurocognitive Disorders and Mental Disorders Due to Another Medical Condition). The next focus should be on the patient's thought process and content, assessing for deficits in reality testing that are indicative of psychosis (see Chapter 4, Schizophrenia and Other Psychotic Disorders).

The Difficult-to-Engage Patient

Some patients may give excessively brief responses, speak repetitively, become vague, or talk about matters that are not immediately relevant. When the difficulty is not related to cognitive impairment or psychosis, the interviewer may attempt to engage the patient through open-ended follow-up questions and nondirective encouragement. If these techniques are unsuccessful, the interviewer must turn his or her attention to the process of the interview.

As a guiding principle, the psychiatric interviewer should focus on process before content whenever there seems to be a barrier to the free flow of information. The physician's role extends beyond simply gathering information to addressing the impediments to communication. In many situations, the very problems the patient is having with the interview may be related to the problems that led to presentation in the first place. As the case example in Box 2.5 illustrates, the most useful interventions in stalled initial interviews are often observations about the process. Once the impediment to the patient's talking freely has been expressed and understood, the flow of information can resume. At the same time, the patient's inner experience will be understood in greater depth, illustrating how the diagnostic and therapeutic dimensions of the psychiatric interview are interwoven.

BOX 2.5

INTERVIEW EXAMPLE DEMONSTRATING USEFULNESS OF ADDRESSING PROCESS BEFORE CONTENT

A 23-year-old man presented to an outpatient clinic for treatment. In the initial evaluation, he began by saying that he had been feeling depressed over the past few weeks. He was unemployed and living with his mother, who supported him financially. The patient explained that he couldn't find a job "because of the depression." At this point, the patient looked at the doctor expectantly. After a pause, the interviewer attempted to draw the patient out.

Interviewer: Tell me more about that.

Patient: That's basically it. I've just been depressed, and I wanted to know what medications were available.

I: It sounds like it's been a difficult time for you. Can you tell me more about what you think happened and what you are experiencing now?

P: Not really. Like I said, I just got depressed a few weeks ago and it's getting in the way of finding a job. And I really need to find a job—to get my mother off my case!

(continued)

I: So your mother has been on your case recently.

P: Yeah.

I: I'd like to understand all this in greater detail so that I can be of help to you. You began by saying you've been depressed for a few weeks. How did that come about and how you do understand it?

P: I don't know. I don't really think it's that important.

A few more attempts at engaging the patient were unsuccessful, with the patient continuing to give terse responses. At this point, very early in the interview, the interviewer might be tempted to resort to the list of symptoms of a major depressive episode, asking yes-no questions about them. This approach would not be altogether misguided, as the interviewer will need to establish answers to these questions before the evaluation is complete. However, the interviewer will have missed a crucial opportunity to understand and address the patient's resistance, which may be conscious or unconscious (see Chapter 17, Psychotherapy). Turning to process before content, the physician can further her understanding of the patient as well as the patient's understanding of himself.

In the vignette, the interviewer observed that the patient grew relatively passive in the interaction, while the interviewer herself became the active member of the team, attempting to engage the patient by repeated questions. It is as if something of what the patient described with his mother was recreated in the interview: the patient is not working, and the interviewer is on his case! The physician could comment on the process by saying, "I wonder whether something is making it difficult to talk freely right now" or, "I have the impression this isn't easy to talk about with me." If the physician speculates that the resistance is due to a displacement of the patient's feelings about his mother onto the physician, she could say: "I can see that it's difficult for you to tell me about the problems for which you're seeking help. Talking at more length feels useless to you. I've noticed that a version of what is happening at home is also happening right now, almost as if I'm getting on your case, asking you to do something you're not doing. And if I were like your mother, whom you've told me is angering you recently, I can understand a bit more about why you might not want to talk or get too invested by sharing more of yourself with me."

These types of interventions can help patients feel understood and reveal more about their inner state. The patient in the example is difficult to engage, but the psychological sources of his resistance are not yet clear. For example, the patient could be feeling hopeless about the treatment already, or paranoid about the doctor's intentions. He might be feeling a sense of shame or even humiliation in revealing that he has been depressed, or he might feel particularly anxious or exposed, or even angry, consciously or unconsciously, toward the doctor for some reason. These would all be important aspects of the patient's experience and clinical presentation to know about and understand in greater depth, as each of these possible sources

(continued)

of difficulty engaging will have implications not only for the remaining conduct of the interview but also for diagnosis and treatment planning. Addressing the process of the interview allows the patient to clarify his experience.

When the physician asked whether something was making it difficult to talk freely, the patient explained that he didn't believe the interviewer could really help him. In fact, he didn't really believe in psychiatry at all; he just wanted to try the medication to appease his mother. Here the interviewer made an empathic comment: "I can see then why it would be difficult for you to tell me about your problems. You feel hopeless that it could lead to anything productive." In response to the physician's intervention, the patient did feel understood and said more about his skepticism of psychiatry. The physician followed the affect: "I wonder whether feelings of hopelessness or a sense of having to appease your mother—whether these things come up in other situations, with other people in your life." The patient then went on to elaborate how futile it seemed that anyone could help him, which led him to elaborate spontaneously on his life situation, significant early losses, and his problematic relationship with his mother. The patient was speaking freely.

Over the course of the initial interview, the patient grew increasingly animated and connected with the physician, who recommended they meet again to continue the evaluation. The patient agreed, and a potential treatment was underway.

Past Psychiatric and Medical History

The interviewer should fill in the details of the patient's past psychiatric and medical problems as well as treatment, inquiring in a systematic and detailed manner. In general, the interviewer will prioritize information according to the clinical situation; in a busy emergency room, for example, the physician will focus this section of the interview on that information which is essential.

Crucial past psychiatric history includes psychiatric hospitalizations, symptoms of psychosis and mood disorders, suicide attempts, self-injury, violence, dangerously impulsive behavior, arrests, incarcerations, and previous outpatient treatment. The task is not simply to compile a disconnected list of facts but instead to make narrative sense of them. For example, if a patient reports two past suicide attempts, the interviewer should address them one by one, inquiring about all details leading up to and surrounding each attempt as well as the subsequent treatment. With regard to past hospitalizations, the psychiatric interviewer wants to know what led to a hospitalization, why it was necessary, what the precipitating factors might have been at the time, what the inpatient course entailed, and what the discharge plan and follow-up treatment involved. For example, if a patient reports that she saw a psychiatrist for 6 months after leaving the hospital, the interviewer will want to know how and why the treatment ended. The more time available for the interview, the more the physician should explore the past history, oscillating between open-ended listening and focused questioning. Even when the time is limited, the facts should be placed in a context. Throughout this section of the history-taking, the principles of empathic listening apply. In gathering past psychiatric and medical history—major events and stories that inevitably entail emotional experiences—the physician will

deepen his or her knowledge of the patient, thus enhancing the physician's capacity for empathic understanding of and emotional contact with the patient.

Review of Systems

A psychiatric interview should include a **review of systems**, in which the patient's past and present mental health is surveyed to identify signs and symptoms in the major realms of psychopathology. Here the interviewer uses as a guide the leads noted during the more open-ended phase of history-taking: anything the patient has said—or notably not said—that suggests psychiatric illness, disturbances, or difficulty in functioning. Sometimes, a patient may report one problem but not another—because it occurred in the past, is happening in the present with minor symptoms, or is manifest in the present and the patient does not realize it. Almost always, however, hints of any major illnesses are revealed by the present complaints. The interviewer should pursue the possible presence of certain ailments even when they are not spontaneously elaborated. For example, a patient who has presented for evaluation of panic attacks mentions that he was depressed in college and at another point makes reference to recent weight gain. During the closed-ended questioning, the interviewer should follow up on this lead, working backward from the present by asking how the patient's mood has been recently, given all that has been going on. This opens an exploration of whether the patient is currently depressed. It is neither desirable nor possible to question every patient about every category of symptoms. The physician's judgment will modify how detailed and exhaustive the review of systems should be. Box 2.6 includes examples of the types of questions that can be used in surveying the realms of psychopathology.

BOX 2.6

SCREENING QUESTIONS FOR A PSYCHIATRIC REVIEW OF SYSTEMS

MOOD DISORDERS (SEE CHAPTER 3)

Depression

Have you ever had a period when you were feeling depressed or down most of the day nearly every day? What about a time when you lost interest or pleasure in things you usually enjoyed?

Mania

Have you ever had a period of time when you were feeling so good, "high," excited, or hyper that other people thought you were not your normal self or you were so hyper that you got into trouble? What about a time when you were feeling irritable or angry every day for at least several days?

SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS (SEE CHAPTER 4)

Now I'd like to ask you about unusual experiences that people sometimes have.

Delusions

Has it ever seemed like people were talking about you or taking special notice of you? *If yes:* Were you convinced they were talking about you or did you think it might have been your imagination?

(continued)

What about receiving special messages from the TV, radio, or newspaper, or from the way things were arranged around you? What about anyone going out of their way to give you a hard time, or trying to hurt you? Have you ever felt that you were especially important in some way, or that you had special powers to do things that other people could not do? Have you ever felt that something was very wrong with you physically even though your doctor said nothing was wrong . . . like you had cancer or some other terrible disease? Have you ever been convinced that something was very wrong with the way a part or parts of your body looked? Have you ever felt that something strange was happening to parts of your body? Have you ever had any unusual religious experiences? Have you ever felt that you had committed a crime or done something terrible for which you should be punished? Were you ever convinced that your spouse or partner was being unfaithful to you? *If yes:* How did you know they were being unfaithful? Did you ever feel you had a special, secret relationship with someone famous, or someone you didn't know very well?

Hallucinations

Did you ever hear things that other people couldn't, such as noises, or the voices of people whispering or talking?

NEUROCOGNITIVE DISORDERS (SEE CHAPTER 5)

Have you or has anyone close to you ever felt that you had a problem with your memory or with remaining alert, knowing where you were, why you were there, or whom you were with?

ANXIETY DISORDERS (SEE CHAPTER 6)

Panic Disorder

Have you ever had a panic attack, when you suddenly felt frightened or anxious or suddenly developed a lot of physical symptoms?

Agoraphobia

Were you ever afraid of going out of the house alone, being in crowds, standing in a line, or traveling on buses or trains?

Social Phobia

Was there anything that you have been afraid to do or felt uncomfortable doing in front of other people, like speaking, eating, or writing?

Generalized Anxiety

In the last 6 months, have you been particularly nervous or anxious? Do you also worry a lot about bad things that might happen?

OBSESSIVE-COMPULSIVE DISORDER (SEE CHAPTER 6)

Have you ever been bothered by thoughts that didn't make any sense and kept coming back to you even when you tried not to have them? Was there ever anything that you had to do over and over again and couldn't resist doing, like washing your

(continued)

hands again and again, counting up to a certain number, or checking something several times to make sure that you'd done it right?

STRESS DISORDERS (SEE CHAPTER 6)

Sometimes things happen to people that are extremely upsetting—things like being in a life-threatening situation like a major disaster, very serious accident, or fire; being physically assaulted or raped; seeing another person killed or dead, or badly hurt; or hearing about something horrible that has happened to someone you are close to. At any time during your life, have any of these kinds of things happened to you? *If yes:*

Sometimes traumatic experiences keep coming back in nightmares, flashbacks, or thoughts that you can't get rid of. Has that ever happened to you? What about being very upset when you were in a situation that reminded you of one of these terrible things?

ALCOHOL AND SUBSTANCE USE DISORDERS (SEE CHAPTER 7)

Has there been any time in your life when you had five or more drinks on one occasion? Have you ever gotten "hooked" on a prescribed medicine or taken a lot more of it than you were supposed to?

Have you or anybody important to you ever thought that you have a problem with alcohol or other drugs?

EATING DISORDERS (SEE CHAPTER 9)

Anorexia Nervosa

Has there ever been a time when you weighed much less than other people thought you ought to weigh? *If yes:* Why was that? How much did you weigh?

At that time, were you very afraid that you could become fat?

At your lowest weight, did you still feel too fat or that part of your body was too fat?

Bulimia Nervosa

Have you often had times when your eating was out of control? *If yes:* Tell me about those times. *If unclear:* During these times, do you often eat within any 2-hour period what most people would regard as an unusual amount of food? Tell me about that.

Did you do anything to counteract the effects of eating that much? Like making yourself vomit; taking laxatives, enemas, or water pills; strict dieting or fasting; or exercising a lot?

Were your body shape and weight among the most important things that affected how you felt about yourself?

SUICIDE (SEE CHAPTER 12)

No psychiatric evaluation is complete without an assessment of suicidal thoughts and attempts.

Have you ever wished you were dead or wished you could go to sleep and not wake up?

(continued)

Have you had any thoughts about killing yourself?

Have you ever done anything, started to do anything, or prepared to do anything to end your life?

From First, M. B., R. L. Spitzer, M. Gibbon, and J. B. W. Williams. Structured Clinical Interview for DSM-IV-TR Axis I Disorders–Patient Edition *(SCID-I/P) revised January 2007.*

Psychosocial History

The prospect of eliciting and organizing a detailed narrative of the patient's life can seem overwhelming. The length of time spent in the interview specifically asking questions about the patient's psychosocial history, and the level of detail elicited, will vary. But the interviewer should appreciate that many contextualized facts about and events in the patient's life may already have emerged in the course of the interview. These include details such as whether the patient is religious; where and with whom the patient lives; his or her education and occupation, activities, and passions. More closed-ended questions will add to the existing sketch (see Box 2.7). Questions about a patient's legal history, drug use, and physical or sexual abuse may not flow naturally in the course of the interview. The interviewer should ask the patient directly about these matters in a straightforward and open fashion, consistent with the rest of the inquiry.

If necessary, the physician can expand this phase of the interview to gather more information about the patient's psychological, social, sexual, and academic development and functioning. A more elaborated psychosocial history may explore in greater depth the patient's family of origin: the personalities and significant events in the lives of parents

BOX 2.7

QUESTIONS TO ELICIT THE MINIMUM ESSENTIAL PSYCHOSOCIAL HISTORY

- Where were you born and reared?
- What were your family's financial circumstances?
- Were your parents married?
- Do you have siblings?
- How far did you go in school?
- Do you work and support yourself?
- Are you in a relationship?
- Are you married?
- Do you have children?
- Where and with whom do you live?
- On whom do you rely for support?
- Have you ever been physically or sexually abused?
- Have you ever been arrested or done things that would have gotten you arrested if you had been caught?

and siblings; significant aspects of the family's history and worldview; the relationships among members of the family, and significant events or losses in the life of the family as a whole. The patient's prenatal and perinatal history can be relevant from a biological and a psychological perspective. Was the pregnancy planned? Were there any notable complications during gestation or following delivery? Next, the interviewer will survey the patient's early, middle, and late childhood, inquiring about developmental milestones, important relationships, and significant life events. As the interviewer reviews the years before, during, and after adolescence, the following information will be of interest: school performance; friendships; life outside of family; areas of pleasure and strength; and evidence of identity consolidation, as manifested in coherent, nuanced, consistent, and three-dimensional descriptions of himself or herself and others—that is, their values, priorities, and salient characteristics. The physician should also inquire about the patient's sexual history, including the patient's first sexual experiences, sexual orientation, and current sexual fantasies and behaviors. The interviewer will also want to learn about the patient's significant adult friendships, experiences in love and intimate relationships, as well as the capacity for commitment to these relationships. Finally, the patient should be asked about finances. Do you have financial concerns? Have current difficulties caused problems at work or reduced your income? Are you able to pay your bills? The patient's history of legal problems and substance use should be covered in detail during this phase of the interview if they were not reviewed earlier.

This more elaborate and extensive psychosocial history is generally not covered in a single interview, but emerges in multiple interviews over the course of an evaluation or treatment. Here again, whether in contracted or expanded fashion, the goal is the same: the interviewer is aiming not just for sequential, isolated facts but for the story, the plot, that connects those facts. A series of questions should not be asked in a rote, checklist, impersonal fashion. The interviewer needs to follow the patient's story naturally, being interested in the significant events, who the main characters are, what has motivated the patient, and what conflicts, crises, or tragedies have been encountered. The physician is trying to understand the patient's **emotional history**, which focuses on emotional reaction patterns, typical responses to stress, coping strategies, and the dominant themes and repetitions that occur in relationships. Information about basic relationship patterns and tendencies with significant others will enable the physician to anticipate the characteristic ways in which the patient is likely to respond both to physicians and to treatment. Finally, the patient's **cultural identity** must be taken into account (see Box 2.8).

The most useful interviewing technique for eliciting the psychosocial history is the same technique employed in the opening phase of the interview. The interviewer may begin with a statement as simple as "Tell me about your life." Then the interviewer listens actively, albeit quietly, initially speaking only to encourage the patient to continue talking or to address resistances that the patient cannot overcome alone. Box 2.9 includes additional examples of questions relevant to the psychosocial history.

Family History

The family history of psychiatric and medical illnesses is obtained in the course of any complete psychiatric interview. Psychiatric illnesses result from a combination of biological and environmental factors, and the family history of illness gives information about both. Psychiatric and medical illnesses in parents, siblings, grandparents, aunts, uncles, and cousins should be investigated. The physician should ask specifically about any known history of attempted or completed suicide; mental illnesses including depression,

BOX 2.8

CULTURE AND THE PSYCHIATRIC INTERVIEW

Culture refers to the systems of knowledge, ideas, beliefs, and practices that are inherited, recreated, and molded from generation to generation, within families and other social institutions. The components of a person's culture that are relevant to the psychiatric interview include language, family structure, social and community structure, concepts of health and illness, religion and spirituality, ways of seeing and understanding the world, as well as general beliefs about the stages of the life cycle.

A person's cultural background, beliefs, and ideals shape to varying degrees how he or she characteristically thinks and behaves. The interpretive framework provided by his or her culture determines a person's experience and expression of psychiatric signs and symptoms. It can also influence the patient's encounter with the psychiatric interviewer. In contemporary life, we are exposed to multiple cultures, and we draw from these cultures as we shape our identities and make meaning out of experience. Because culture at large is a dynamic, changing system—individually experienced but collectively maintained—the cultural factors influencing a person's life should not be generalized or stereotyped.

The cultural factors that influence a patient cannot really be separated from who he or she is as a person. The physician should attempt to uncover and define the cultural context within which the patient lives and suffers as they emerge from the patient's individual story and point of view. Cultural considerations apply to everyone, not just underserved or unfamiliar racial or ethnic minorities within a given society. The interviewer should not inquire generically about the views of the groups with which patients self-identify or to which the physician has ascribed them. The intracultural heterogeneity of beliefs should be allowed to emerge. Since individuals create personal beliefs out of diverse cultural influences in their lives, the cultural dimension of a patient's illness must be considered on an individual, personalized basis (Lewis-Fernandez and Aggarwal, 2013).

Culture frames the experience of mental health and illness for both patient and physician in three primary ways. First, what is normal, expected, and acceptable with regard to thoughts, feelings, and behavior may differ across cultures, families, and social institutions. Therefore, the level at which a patient's experience is considered problematic or pathological varies; it is shaped by cultural norms that have been internalized by the physician, the patient, and those around them. When cultural factors are taken into account, the physician can identify the ways in which a patient has culturally interpreted psychopathology that would result in delaying care and prolonging distress. For example, a religious 60-year-old Russian Orthodox woman believes her major depression is punishment for her sins; and an 18-year-old woman's intensely shy, socially reticent behavior, signifying social anxiety disorder, is

(continued)

normalized by her family and experienced by the patient and others as respectful and appropriate for a young, unmarried woman. Culture may also influence the patient's sense of vulnerability and the intensity of his distress. For example, a 50-year-old Dominican man's local family culture, using rich somatic idioms to express emotional states, amplifies his somatization, contributing to fears that maintain panic disorder and frequent emergency room visits.

Second, cultural factors contribute directly both to the degree of stigma associated with mental illness and to the social and familial response. A patient's culture may offer useful coping strategies that enhance resilience. Cultural norms may also determine the types of interventions and treatments the patient seeks out, including alternative and complementary systems of health care. Cultural factors can influence the patient's acceptance or rejection of a psychiatric diagnosis, adherence to treatments, and the patient's concept of mind both biologically and psychologically. All of these have implications for the course of illness and recovery.

Third, cultural similarities or differences between physician and patient can contribute to the accuracy of diagnosis as well as to the patient's acceptance of a diagnosis and engagement in treatment (see case example in Box 2.2). Patients and physicians who appear to share the same cultural background may nevertheless differ in important ways. They may implicitly assume an understanding of each other, and this can lead to overidentification, erroneous or incomplete assumptions, and shorthand manners of speaking that obscure communication, as well as to conscious or unconscious avoidance of certain questions, topics, or realms of psychopathology.

THE INTERVIEW

A detailed inquiry into cultural factors is indicated when significant differences in cultural, religious, or socioeconomic backgrounds between physician and patient cause difficulty in conducting the evaluation, or when the interviewer is uncertain about the fit between the patient's culturally distinctive symptoms and the DSM diagnostic criteria. At other times, the interviewer might have difficulty judging how severe or how impaired the patient is as a result of his or her illness. If the physician and patient disagree about the course of treatment, or if the patient has a history of limited engagement in treatment or nonadherence altogether, specific attention to cultural factors is warranted.

The following are examples of questions that should be asked during a cultural interview. They can be incorporated into the interview at appropriate and natural moments.

- We all understand our problems in our own way, and these may be different from how doctors describe them. Would you describe things differently if you were talking to your family or friends?
- What bothers *you* the most about your situation?

(continued)

- How do you understand what is going on?
- What do you think is causing it?
- How do your family and friends make sense of what's happening with you?
- Is there some kind of specific support that only your family or friends, or your activities, provide? What are they? How do they help?
- What are the most important aspects to you of your background or identity? By that I mean things like communities you belong to, your religion or faith, gender or sexual orientation, languages you speak, your race or ethnic background, your family's history and traditions?
- Does your background or identity affect your illness? How?
- It's natural for people to look for help from people they trust. What kinds of advice or treatment have you sought for your difficulties—from other doctors or other types of healers? How were they? Which ones seemed to help?
- Has anything prevented you from getting help or from coming in sooner?"
- What kind of help do you think you need right now; what would be most helpful from your perspective, for your situation?
- Have family or friends, or others important to you, suggested things they think might be helpful to you?
- It's always possible that doctors and patients don't understand each other—for all kinds of reasons. Are you concerned, today with me, that I've missed something important?
- Have you been worried, today with me, that we've misunderstood each other?

bipolar disorder, schizophrenia and other psychotic disorders; and neurocognitive disorders. The interviewer should also inquire about a family history of alcohol and substance abuse. Throughout this phase, the physician needs to listen empathically, trying to discern the impact on and relevance to the patient of any positive family history of mental illness.

Mental Status Examination

Most of the information needed for the mental status examination is obtained simply through observation and active listening (see Chapter 1, Psychiatric Assessment and Treatment Planning). Establishing the presence of psychotic symptoms can be among the most challenging aspects of the psychiatric interview. Psychotic fears or beliefs may be unrecognized by the patient or actively withheld from the interviewer. The physician's sense that something is off may stem from the content or from the process of the interview. In the course of telling his or her history, the patient may reveal unusual ideas, irrational beliefs, or intense distrust. In the process, the patient may appear vague, rigid, guarded, or evasive. In such cases, or when aspects of a patient's story seem strange, illogical, contradictory, or incomprehensible, the physician should focus on the patient's reasoning and use of evidence to support his or her beliefs. When there is a question of psychosis

BOX 2.9

QUESTIONS TO ELICIT AN ELABORATED PSYCHOSOCIAL HISTORY

- What is your earliest memory?
- Tell me about your childhood.
- Where were your parents born?
- When did you (they) come to this country? From where? Under what circumstances?
- Where did you grow up?
- In how many places have you lived?
- Who lived at home? Parents? Siblings? Grandparents?
- Were you ever separated from a parent for any length of time?
- Did you have any operations or serious illnesses or accidents as a child?
- How much schooling have you and your other family members had?
- How did you do in school (elementary school, junior high or middle school, high school, college)?
- Tell me about your friendships (in grade school, adolescence, college, in recent years).
- Does religion play an important role in your life? Do you consider yourself a spiritual person?

and the patient is guarded in the interview, the physician could say: "I can see that you'd like to keep that private or are having difficulty talking openly about it with me. Is there something you're worried about?" This can be followed by addressing the doctor–patient relationship, asking: "Are you feeling suspicious of me—my intentions or motivations?" When possible delusions have been identified, the physician should explore the patient's reality testing directly: "I can see how convincing it seems. But I'd like to clarify: is it at all possible that there is another explanation?" or "It makes sense that you're scared, since you believe you have a brain tumor the doctors can't detect. But do you think it's possible that the imaging is correct, and that there is no tumor?"

Formal cognitive testing usually does not flow with the rest of the interview and will need to be introduced specifically with a neutral statement such as, "Now I'm going to ask you some questions to assess your memory and concentration" (see Chapter 5, Neurocognitive Disorders and Mental Disorders Due to Another Medical Condition).

Concluding Phase

The conclusion of a psychiatric interview will depend on the nature and purpose of the interview, as well as on such factors as whether there will be further interviews and whether the situation is an emergency. In all cases, the physician should allow time for the closing phase of the interview. In this phase, the interviewer asks whether any important history was omitted. An introductory statement might be, "We have some time left. I'm wondering whether I've missed anything you think is important. For example, something you had wanted to tell me but didn't." Or: "Is there anything you think I should

have asked you but haven't yet?" Even after a lengthy interview, a patient may make surprising revelations.

The physician then shares the impressions and treatment recommendations with the patient in a sensitive, culturally informed manner, employing language and concepts that the patient and other laypersons can comprehend. It is important to allow time for the patient to respond and react to what has transpired. When necessary, patients should be given time to regain their composure and leave with dignity.

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/// 3 /// Mood Disorders

LICÍNIA GANANÇA, DAVID A. KAHN, AND MARIA A. OQUENDO

Mood disorders are a significant public health problem. They are relatively common, and their recurrent nature profoundly disrupts patients' lives. Depression afflicts one in eight Americans during his or her lifetime and costs the U.S. economy more than $43 billion annually in medical treatment and lost productivity.

Despite the seriousness of mood disorders, only one-third of individuals with these disorders are properly diagnosed or treated. Studies have found that although 20% of patients in primary care clinics were clinically depressed (Olfson et al. 2000), only one-half were diagnosed as such by a physician (Rost et al. 1998; Wells et al. 1989). Several factors might account for this underrecognition. First, in general medical settings, many patients with mood disorders present with unexplained somatic complaints, especially pain and insomnia, rather than a clearly stated emotional complaint, the so-called masked depression. Second, it can be difficult to distinguish mild mood disorders from the normal emotional ups and downs of life. Third, **stigma** remains a barrier to seeking help for mental illness. Most people—and, sometimes, even physicians—tend to fear, look down upon, or ignore mental illness. In order to avoid the risk of being seen as weak in their own eyes or the eyes of others, many individuals with mood disorders choose not to get professional help, preferring to "tough it out." This attitude sometimes results in dire consequences for ill persons and their families, as 10% to 15% of patients with severe mood disorders die from suicide.

Mood disorders are neither normal variations in mood nor appropriate reactions to severe stress. These disorders are distinguished from normal moods and reactions by the duration and intensity of patients' suffering and the degree of their functional impairment. Mood disorders do not represent a failure of "will power" or some other form of moral weakness. Fortunately, there is a growing recognition that mood disorders are medical illnesses that require aggressive diagnosis and treatment by physicians.

DIAGNOSTIC AND CLINICAL FEATURES

Mood can be understood as the amalgam of emotions that a person feels over time, the general emotional state that "colors" the person's perception of the world. Mood is characterized by features such as intensity, duration, fluctuations, and the adjectival description

of type (depressed, expansive, irritable, euthymic). **Emotions** are more ephemeral affective states caused by physiological changes in response to an event and are usually accompanied by somatic symptoms. Examples of emotions are happiness, fear, anger, and disgust. **Affect** is the way in which emotions are displayed as observable behaviors such as through body language, including facial expression. The effects of mood on a person's behavior are complex and widespread. Mood shapes conscious attention, interest, and motivation, and it alters unconscious autonomic functions, such as those related to vagal tone and sleep physiology. Many physical sensations, such as energy, pain, muscle tension, hunger, satiety, and sexual pleasure, have strong emotional components that influence the production and intensity of these sensations; thus, changes in a person's mood state can effect changes in energy and behavior.

Constricted emotional range, a decrease in the usual repertoire of emotional responses the individual displays, can occur in mood disorders and stands in contrast to normal emotional experience. Patients with mood disorders are emotionally stuck. Because one or more emotions persist more intensely and for a much longer time than circumstances warrant, these patients lose much of their emotional flexibility and, therefore, their ability to adapt to changing circumstances; they have trouble "shifting gears" within a normal repertoire of complex emotions. Normally, after a loss or victory, a person has intense feelings of sadness or elation for a time, which gradually give way to new responses to life's events. After the loss of a romantic attachment, for example, some depressed individuals repeatedly experience symptoms so severe that they are unable to get out of bed for weeks. In contrast, some persons experience a manic "high" and become so euphorically obsessed with a speculative investment strategy that they are unable to experience warning signs, such as self-doubt, and eventually suffer financial harm.

Mood is also closely linked to **cognition**. For example, research into memory physiology suggests that perceptions and thoughts (i.e., "what happened") are best retained when they are linked with strong emotional memories (i.e., "how it felt"). In persons with mood disorders, a filter is introduced that distorts normal perceptions and memories or subjects them to selective recall. This distorting process can dramatically affect a central aspect of mood, self-worth. **Self-worth** is one component of a person's permanent self-image that stretches over time and includes perceptions of past experiences, current abilities, and future plans. In patients with mood disorders, the perception of self-worth goes through unstable gyrations. Typically, a depressed patient views past events with undue criticism and guilt, feels worthless, and finds the world an unpromising place. In contrast, manic patients glorify their abilities and find the world a stimulating place.

The mood disorders consist of the **depressive** and **bipolar disorders**. These disorders are recognized as distinct groups because they share both specific symptoms and features of a longitudinal course. The predominant symptom of any mood disorder is **a distinct period of abnormally and persistently altered mood**. Bipolar disorder, also known as **manic-depressive illness**, is distinguished from depressive disorders by the presence of manic or hypomanic (i.e., mildly manic) episodes that can occur in addition to depressive episodes. Of note, a diagnosis of bipolar I disorder can be made in the absence of depressive episodes. Figure 3.1 schematizes these categories. Most depressed patients feel sad or "low," and most manic patients feel irritable, euphoric, or "high." Patients with mood disorders also experience behavioral, cognitive, and psychomotor changes, which may constitute their presenting complaints.

The key feature of the longitudinal course of mood disorders is a tendency toward **cycles of recurrence**. Although some patients have only a single episode during their lives, most have multiple episodes, or recurrences, interspersed with periods of remission,

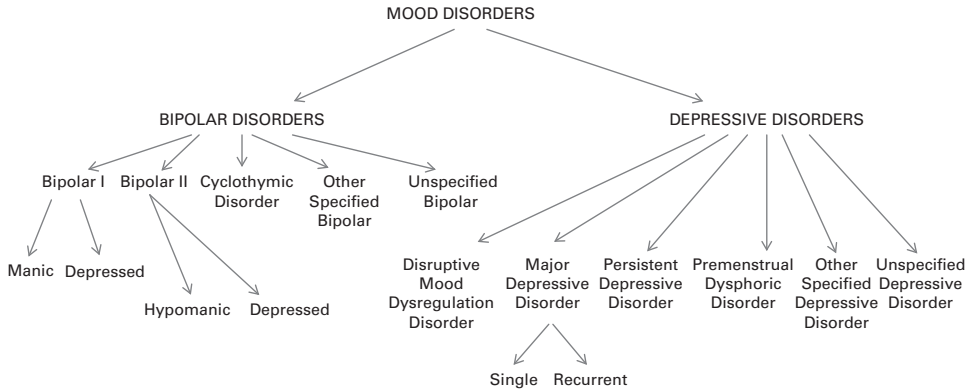

FIGURE 3.1 Overview of the mood disorders classification. Patients with bipolar disorder have had at least one episode of mania or hypomania. Bipolar I disorder consists of recurrences of mania and major depression. Bipolar II disorder consists of recurrences of major depression and hypomania (mild mania). Cyclothymic disorder consists of recurrent brief periods of mild depressive symptoms and hypomanic symptoms that do not meet criteria for a hypomanic episode. Other specified bipolar and related disorder is for partial syndromes, such as recurrent hypomania without depression. In unspecified bipolar and related disorder the patient does not meet the full criteria for any of the disorders in the bipolar and other disorders class; this diagnosis is best suited for situations where information is limited, such as in emergency room settings. Depressive disorders include major depressive disorder, which is often recurrent but sometimes occurs as a single lifetime episode, as well as persistent depressive disorder (dysthymia), disruptive mood dysregulation disorder, and premenstrual dysphoric disorder. Other specified depressive disorder is the diagnostic term for partial syndromes, such as patients who are depressed but have too few criteria for major depression and whose depression has been too brief for persistent depressive disorder. Unspecified depressive disorder represent cases where full criteria for any of the depressive disorders are not met and, as for unspecified bipolar disorder, can be used when there is insufficient information to make a more specific diagnosis.

known as **euthymia**, or normal mood. Some patients have chronic symptoms and never achieve full recovery. As with many other major medical illnesses, the prevention of relapse and the recognition of persistent low-grade symptoms between episodes are critical elements in the long-term treatment of patients with mood disorders.

Major Depression

Psychological Symptoms and Signs

Patients with major depression have a persistent, distinct feeling of depression or loss of pleasure or interest in usual activities that lasts for at least 2 weeks, as well as at least four associated symptoms (see Table 3.1). When describing a **depressed mood**, patients often say they feel sad or "blue," are "down in the dumps," have an ache or an empty feeling in their heart or in the pit of their stomachs, or feel the need to cry. In addition, other emotional states such as anxiety, irritability, or even hostility can also appear. **Sad feelings** are often accompanied by persistently lowered self-esteem or self-criticism. These are two features generally not observed in persons who are responding to external losses. In his classic paper "Mourning and Melancholia," Sigmund Freud noted that mourners

TABLE 3.1 DSM-5 Diagnostic Criteria for Major Depressive Disorder

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure:

Note: Do not include symptoms that are clearly attributable to another medical condition.

(1) Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, or hopeless) or observation made by others (e.g., appears tearful). (**Note:** In children and adolescents, can be irritable mood.)

(2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).

(3) Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (**Note:** In children, consider failure to make expected weight gain.)

(4) Insomnia or hypersomnia nearly every day.

(5) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).

(6) Fatigue or loss of energy nearly every day.

(7) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).

(8) Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).

(9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the physiological effects of a substance or another medical condition.

Note: Criteria A–C represent a major depressive episode.

Note: Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss.

D. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.

E. There has never been a manic episode or a hypomanic episode.

Note: This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance-induced or attributable to physiological effects of another medical condition.

(continued)