Psychiatry History Taking

Third Edition

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Evaluation of the Psychiatric Patient

I. Establishing rapport

A. The first step in interviewing a psychiatric patient is to establish rapport and create an environment where the patient feels comfortable disclosing personal information. The examiner should begin by introducing himself and stating the purpose of the interview.

B. The examiner should be caring, competent, and concerned about helping. Good listening will often provide the patient with confidence in the examiner and facilitate trust and openness.

II. Interview structure

A. The structure of the clinical interview does not usually follow a rigid format. It is best to guide the patient through their psychiatric history by listening to specific cues the patient provides and responding with appropriate questions and comments.

B. History taking typically begins with open-

ended questions, which allow the patient to tell the story in his own words. Directed, or more close-ended questions, are used later to elicit specific details when the examiner requires further elaboration.

III. Observation

A. How the patient speaks and behaves is equally important as *what* they say. Assessment begins with simple observation of the patient. Personality characteristics and the way in which patients view themselves and interact with their environment are also considered with the presenting complaint.

B. The emphasis of the clinical interview is to establish a working diagnosis based on Diagnostic Criteria (DSM-IV-TR) and to develop an appropriate treatment plan. Much of the interview is focused on asking specific questions designed to reveal the presence of symptoms consistent with mood, psychotic, and anxiety disorders.

IV. Mental status exam

A. The mental status exam is an assessment that provides a common language to describe patient characteristics. The interview provides data that help to elucidate elements of the patient's presenting complaints and history. The mental status of the patient may change with each exam, and results are relevant only to the time of the interview.

B. When discussing an impression of a patient, it is useful to begin by summarizing the mental status exam.

V. Written format

A. The psychiatric report presents the history in a specific written format. The report includes a proposed multiaxial diagnosis and summarizes the clinical impression and management recommendations.

B. Suggestions for further work-up are also included, such as laboratory testing, neurological examinations, diagnostic testing, and gathering information from family, friends, and other health-care providers.

Interviewing Techniques

Technique	Description
Reflection	Empathic repetition of patient's words to show understanding
Facilitation	Nodding, saying yes, or uh-huh, to help continue the interview
Silence	Allowing the patient time to think or cry
Confrontation	Challenging the patient by pointing out something overlooked or denied
Clarification	Eliciting details and addressing contradictions
Transition	Switching topics
Reinforcement	Giving positive feedback to encourage disclosure
Interpretation	Offering insight to facilitate awareness
Summation	Summarizing information to confirm understanding
Explanation	Explaining the treatment plan and answering questions

Adapted from *Psychiatry Essentials: A Systematic Review*, Hanley & Belfus Inc, 2001

The Psychiatric History

Identifying data: Patient's name, age, gender, marital status, occupation, current living situation, language, and ethnic background.

Chief complaint: Provide the reason that the patient is seeking care using the patient's own words in quotation marks.

History of present illness: Document current symptoms as described by the patient; date of onset, duration and course of symptoms. Obtain a chronological description of recent events leading up to the presentation, precipitating events, and any other psychosocial stressors. This section should include a psychiatric review of symptoms that assesses the presence of affective, psychotic, and anxiety disorders.

Past psychiatric history: Past and current diagnoses; a detailed description of past illness, hospitalizations, and treatments. Include past problems with suicidal thinking and attempts.

Substance abuse history: Alcohol, cocaine, heroin, marijuana, amphetamines, barbiturates, hallucinogens, and prescription medications, such as opioids or benzodiazepines. If alcohol use is present, screen for abuse or dependence with questions about attempts to cut down, anger, guilt, eye-openers, history of blackouts, shakes, seizures, or delirium. Ask about the amount of substance used, money spent daily, weekly, or monthly. Ask about method of use, such as inhaled, intranasal, or intravenous.

Social history: Developmental history if relevant, level of education, social history with attention to important relationships and family conflict; marital history, religion, occupational history, and history of violence or criminal activity. Details of past traumatic events; physical abuse or sexual abuse. This section should cover the major domains of the patient's life, including work, love, and recreation.

Family history: Presence of psychiatric illness in family members, dementia, psychiatric treatment, use of psychiatric medication, presence or history of substance abuse, and history of suicide or suicide attempts.

Past medical history: Past and current medical problems, treatments, and allergies.

Medications: Psychiatric, medical, over-the-counter, and alternative medications.

Mental status exam: General description of the patient's appearance, speech, mood, affect, thought process, thought content, perceptual disturbance, suicidal ideation, homicidal ideation, sensorium and cognition, impulse control, judgment, insight, and reliability (see Mental Status Exam in the following section). The mental status exam should contain enough information to allow other physicians to recognize the patient from the description alone.

Diagnosis: Psychiatry adheres to a biopsychosocial model where problems are understood as consisting of biological, psychological, and social dimensions. Diagnosis is made across five separate axes to delineate primary psychiatric disorders and substance abuse, personality disorders and mental retardation, general medical illness, psychosocial stressors, and global functioning. This multiaxial system supports an approach to understanding the patient, which includes medical, psychiatric, and

social problems.

Axis I General psychiatric conditions and substance-related disorders
Axis II Personality disorders and mental retardation
Axis III General medical conditions
Axis IV Psychosocial stressors
Axis V Global assessment of functioning (GAF) on a scale from one to 100 (see Table 5)

Differential diagnosis: Include all psychiatric, medical, and neurological possibilities.

Assessment/plan: Include the patient's age, gender, working diagnosis, and reason for admission or discharge. Write orders to admit the patient if necessary, specify admission status (eg, voluntary or involuntary), specify observation status (eg, one-to-one, every 20 minutes), consider medical and neurological evaluations, propose treatment, and recommend gathering additional information from family and other health care personnel.

A/P: Mr. Smith is a 45-year-old man with schizophrenia, paranoid type, who presents with command auditory hallucinations telling him to jump off the Golden Gate Bridge in the context of medication non-adherence for the past two months.

- Admit to psych 6, voluntary status, q20 observation
- Check vital signs q shift, regular diet, NKDA
- Restart risperidone at 1 mg bid and titrate as necessary
- Contact outpatient psychiatrist to gather additional information (Dr. Jones, x1234)

Table 5. Global Assessment of Functioning

Score	Description of functioning
91-100	Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.
81-90	Absent of minimal symptoms (eg, mild anxiety), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (eg, an occasional argument with family members).
71-80	If symptoms are present, they are transient and normal reactions to psychosocial stressors (eg, difficulty concentrating after family argument); no more than slight impairment is social, occupational, or school functioning (eg, temporarily falling behind in schoolwork).
61-70	Some mild symptoms (eg, depressed mood or mild insomnia) **OR** some difficulty in social, occupational, or school functioning (eg, occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful personal relationships.
51-60	Moderate symptoms (eg, flat affect and circumstantial speech, occasional panic attacks) **OR** moderate difficulty in social, occupational, or school functioning (eg, few friends, conflicts with peers or coworkers).
41-50	Serious symptoms (eg, suicidal ideation, severe obsessional rituals, frequent shoplifting) **OR** any serious impairment in social, occupational, or school functioning (eg, no friends, unable to keep a job).
31-40	Some impairment in reality testing or communication (eg, speech is at times illogical, obscure, or irrelevant) **OR** major impairment in several areas such as work or school, family relations, judgment, thinking, or mood (eg, depressed person avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).
21-30	Behavior is considerably influenced by delusions or hallucinations **OR** serious impairment in communication or judgment (eg, sometimes incoherent, grossly inappropriate behavior, suicidal, preoccupation) **OR** inability to function in almost all areas (eg, stays in bed all day; no job, home, or friends).
11-20	Some danger of hurting self or others (eg, suicide attempts without clear expectation of death; frequently violent; manic excitement) **OR** occasionally fails to maintain minimal personal hygiene (eg, smear feces) **OR** gross impairment in communication (largely incoherent or mute).
1-10	Persistent danger of severely hurting self or other (eg, recurring violence) **OR** persistent inability to maintain minimal personal hygiene **OR** serious suicidal act with clear expectation of death.
0	Inadequate information

Adapted from *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision, American Psychiatric Association, 2000

The Mental Status Exam

General description: Appearance (clothing, hygiene, posture, body type), behavior (psychomotor agitation, psychomotor retardation, restlessness), and attitude towards the interviewer (cooperative, well-related, guarded, hostile, apathetic).

Speech: Quantity of speech (eg, talkative, sparse), rate (eg, rapid, slow), volume (eg, whispered, loud), spontaneous, impediments (eg, stuttering, lisp), and rhythm.

Mood: Emotional state recorded in the patient's own words (eg, "depressed," "anxious," "scared," "happy," "angry").

Affect: The interviewer's observation of the patient's emotional state, which includes the general quality (eg, dysphoric, euthymic) and depth of the affect (eg, normal, blunted, or flat). Affect may be labile (alternating rapidly between two extremes) or inappropriate (incongruence between subject matter and emotional expression).

Thought process disturbance: Refers to the logical and semantic connections between patient's thoughts (form). Verbal expression can follow a linear and logical train of thought called goal-directed (normal), or lapse into increasing levels of disorganization, such as circumstantial thought processes, tangentiality, flight of ideas, thought blocking, loosening of associations, word salad, or neologisms (see Table 1).

Table 1. Thought Process Disturbance

Thought Disturbance	Description
Circumstantiality	Speech includes irrelevant details but eventually makes a point
Tangentiality	Speech is not goal-directed, and a point is never made
Flight of ideas	Rapid thinking with fast changes in topics; ideas are related, but speech may be difficult to follow
Loosening of associations	Flow of thought with ideas that are coherent but unrelated
Thought blocking	Flow of thought is interrupted by silence, and the patient does not return to the same topic when speech resumes
Word Salad	Individual ideas and speech are incoherent
Clang associations	Word association by rhyming
Neologisms	Creating new words

Adapted from *Psychiatry Essentials: A Systematic Review*, Hanley & Belfus Inc, 2001

Thought content disturbance: Refers to what the patient is thinking. Examples of thought content include suicidal ideation, homicidal ideation, paranoid content, delusions, ideas of reference, obsessions, compulsions, poverty of content, and phobias (see Table 2). General themes that characterize the patient's thinking should be described (eg, anger at their parents).

Table 2. Thought Content Disturbance

Thought Content	Description
Delusions	Fixed, false beliefs without a cultural basis
Ideas of reference	Belief that the television or radio speaks directly to patient
Ideas of influence	Belief that other forces control the patient's behavior
Paranoid ideation	Thoughts of being harmed, followed, or persecuted
Obsession	A recurrent thought experienced as intrusive
Compulsion	A repetitious act designed to alleviate anxiety
Poverty of content	Thought that is vague, repetitious, or obscure
Phobia	An unfounded fear that triggers panic

Adapted from *Psychiatry Essentials: A Systematic Review*, Hanley & Belfus Inc, 2001

Perceptual disturbance: Hallucinations may be auditory, visual, olfactory, tactile, or gustatory. Distinguish between hallucinations and illusions.

Sensorium and cognition: Administer the mini-mental state exam (Table 3), assess abstract vs.

concrete thinking, vocabulary, general knowledge, and overall intelligence.

Table 3. The Mini-Mental State Exam

Category	Instructions to Patient	Maximum Score
Orientation	**"Can you tell me the date?"** year (1), season (1), day (1), date (1), month (1)	5
Registration	**"Where are you?"** state (1), country (1), town (1), hospital (1), floor (1) **"Repeat the names of these 3 objects"** table (1), flower (1), car (1)	5 3
Attention and Calculation	**"Subtract by 7s starting from 100"** 93 (1), 86 (1), 79 (1), 72 (1), 66 (1)	5
Recall	**"Recall the names of the above 3 objects"** table (1), flower (1), car (1)	3
Language	**"Name the object the examiner is holding"** point to a watch (1), point to a pencil (1) **"Say no ifs ands or buts"** **"Take this paper in your right hand** (1), **fold it in half** (1), **and put it on the floor** (1)**"** **"Read this aloud and do what it says"** show the patient a sign that says CLOSE YOUR EYES **"Write a sentence of your own"**	2 1 3 1 1
Construction	**"Copy this design"** show the patient a pair of intersecting pentagons	1

Adapted from Folstein, 1975

Impulse control: Assess the patient's ability to think before acting and their ability to talk about their emotions rather than acting on them.

Judgment: Determine the patient's ability to understand behavior and its consequences, especially with regard to making medical decisions.

Insight: Refers to the patient's awareness and understanding of illness. Does the patient see himself as others do?

Reliability: Accurate and consistent reporting of symptoms, truthfulness, and extent of disclosure.

Depression - History Taking

History of present illness: Current symptoms, duration, date of onset, diurnal variation in severity of symptoms, seasonal variation, and psychosocial stressors. Ask about irritable or depressed mood, loss of interest in previously pleasurable activities, decreased libido, changes in appetite, weight loss or weight gain, decreased energy, too much or too little sleep, psychomotor agitation or retardation, problems with concentration, guilt or regret about the past, hopelessness, and suicidal ideation.

If the patient is suicidal, ask about the presence of a plan. Assess type of insomnia (sleep onset, early morning wakening, difficulty staying asleep, or hypersomnia). Assess severity of depressive symptoms by noting impact on their home, school, or work life.

Rule out bipolar disorder with questions about periods of persistently elated mood, increased self-esteem, racing thoughts, pressured speech, distractibility, increased goal-directed activity, and hedonism. Rule out psychotic features or schizoaffective disorder by asking about hallucinations and delusions.

Past psychiatric history: Previous psychiatric diagnoses, previous depressive or manic episodes, history of panic attacks or other anxiety symptoms, history of psychiatric hospitalizations, including dates and locations, outpatient therapy, past medications, side effects, and adherence to treatment. History of suicide attempts and specific methods employed; assess potential lethality of previous attempts. Panic disorder, posttraumatic stress disorder, and substance abuse are the most common comorbid conditions with major depressive disorder.

Substance abuse history: Assess temporal relationship between any substance use and depressive symptoms. For example, persistent alcohol use or cocaine withdrawal may present with depressive symptoms.

Past medical history: Hypothyroidism, anemia, seizure disorders, migraine headaches, HIV, systemic lupus erythematosus, Parkinson's disease, diabetes, and Cushing's disease may present with symptoms of depression.

Medications: Antihypertensives, oral contraceptives, corticosteroids, analgesics, sedatives, hypnotics, anxiolytics, stimulants, antipsychotics, antibiotics, anticonvulsants, and chemotherapy may cause depressive symptoms.

Mental Status Exam

General description: Stooped or downcast posture, poor eye contact, psychomotor retardation, or sometimes restlessness.
Speech: Decreased volume, slow rate, and normal rhythm; speech may not be spontaneous.
Mood: Often described as "depressed," "sad," or "irritable."
Affect: Constricted in dysphoric range, but congruent with the patient's reported mood.
Thought process: Linear and goal-directed in the majority of patients, but often impoverished.
Thought content: Ruminations of guilt about the past, hopeless about the future, poverty of content, or paranoid ideation; content disturbance may reach delusional proportions in depression with psychotic features.
Perceptual: Auditory, command or visual hallucinations may occur with psychotic features.
Suicidality: Suicidal ideation is present in more than half of depressed patients. A plan needs to

be specified if present. Assess how the patient manages or resists suicidal impulses.
Homicidality: May occur with psychotic features.
Sensorium/cognition: Oriented, some problems with immediate recall (registration), but not delayed recall; concentration is often poor, and language deficits are rare. The patient may have a good fund of knowledge and vocabulary, without disturbance in abstract thinking. The mini-mental state exam score should be greater than 27 unless depressive pseudodementia is present.
Impulse control: Generally intact except when patients have psychomotor agitation or severe anxiety.
Judgment: Often impaired by the intensity of depressive symptoms.
Insight: Distorted with exaggerated emphasis on depressive symptoms.
Reliability: Patients may overemphasize symptoms in the midst of a depressive episode, or minimize symptoms for fear of appearing "crazy."

Laboratory data: Complete blood count, chemistry, thyroid function tests, liver function tests, urinalysis with toxicology screen, blood alcohol level, urine pregnancy test, vitamin B_{12} and folate levels, and HIV in high-risk patients.

Diagnostic testing: The Hamilton Rating Scale for Depression (HAM-D) and the Beck Depression Inventory.

Diagnosis:
Axis I: Major depression, bipolar I disorder, schizoaffective disorder, depressed type.

Differential Diagnosis

Psychiatric: Dysthymia, cyclothymia, bipolar II disorder, substance-induced mood disorder, schizoaffective disorder, bereavement, and adjustment disorder with depressed mood.

Medical: Hypothyroidism, infection, chronic disease, cancer, medications, and vitamin deficiency.

Neurological: Parkinson's disease, dementia, Huntington's disease, temporal lobe epilepsy, cerebral tumors, multiple sclerosis, and head trauma.

Major Depressive Disorder - Discussion

I. **Epidemiology.** Major depression affects up to 10 percent of men and 20 percent of women at some point in their lifetime.

II. **Etiology.** Genetic factors influence the development of depression, and a *dysregulation* of serotonin, epinephrine, and dopamine is the proposed etiological mechanism. These elements interact with psychosocial stressors and increase the patient's vulnerability to affective disturbance.

III. **Clinical evaluation**

- **A. The diagnosis of major depression** requires at least five of the following nine symptoms for a duration of at least two weeks: depressed mood, decreased interest in activities, appetite changes, sleep changes, psychomotor agitation or retardation, loss of energy, feelings of guilt or worthlessness, poor concentration, and suicidal ideation.
- **B.** In evaluating the patient with depression, the history of present illness should describe the full extent of symptoms. The time course is important in excluding differential diagnoses, such as dysthymia, bereavement, and adjustment disorder, and in including seasonal pattern or postpartum specifiers.
- **C.** The examiner should ask about suicidal ideation and the presence of a plan. The majority of patients with depression will have suicidal thinking and 10-15 percent will eventually commit suicide. Previous suicide attempts and feelings of hopelessness are associated with an increased risk of suicide.
- **D. Anxiety symptoms** and disorders frequently occur with major depression and also increase suicide risk. Comorbid substance abuse is also a common finding in depression, and substance-induced mood disorders should be excluded.

IV. **Treatment**

- **A.** Patients with clinical depression may require hospitalization for suicidal ideation, or if they are unable to care for themselves in their daily lives. Constant visual observation (1:1) should be considered in suicidal patients.
- **B.** In treating the patient with major depression, most evidence supports the integration of antidepressant medication and psychotherapy. The specific choice of antidepressant typically depends on symptom patterns and differing side effect profiles. For example, a more sedating antidepressant, such as paroxetine, would be used for patients who experience anxiety and insomnia in their symptom profile. Fluoxetine is considered a more activating antidepressant and can be used in patients with poor energy and hypersomnia.
- **C.** Psychotherapy options include cognitive, behavioral, interpersonal, group, family, and psychodynamic psychotherapy.

References, see page 92.

Mania - History Taking

History of present illness: Current symptoms, duration, and date of onset. Irritability, elevated mood, euphoria, inflated self-esteem, and grandiosity. Ask the patient how much he or she has been sleeping; ask about energy during the day. Racing thoughts, talkativeness, distractibility, and psychomotor agitation. Increased goal-directed activity, excessive involvement in pleasurable activities, hypersexuality, disrobing in public, money spending, risk-taking behavior, and pathological gambling. Ask about religious preoccupation and political preoccupation.

Assess psychotic features, such as grandiose delusions, paranoid delusions, mind reading, ideas of reference, ideas of influence, thought broadcasting, or other special powers. Assess for concurrent or alternating depressive symptoms.

Past psychiatric history: Past hospitalizations, diagnoses, treatments, and outpatient follow-up. Past depressive symptoms, depression during adolescence, manic episodes, psychotic symptoms, suicide attempts, comorbid alcohol and other substance abuse.

Substance abuse history: Alcohol, cocaine, heroin, marijuana, hallucinogens, benzodiazepines, barbiturates, and analgesics.

Social history: Living situation, psychosocial support, marital status, employment, and level of education. Note extent of recent stressors, including impact of manic symptoms on relationships and occupational functioning.

Family history: History of depression, bipolar disorder, psychotic disorders, suicide, and substance abuse in family members.

Past medical history: Ask about all medical and neurological problems because many diseases can cause symptoms consistent with mania (see differential diagnosis).

Medications: Antidepressants, amantadine, bromocriptine, corticosteroids, disulfiram, isoniazid, levodopa, procarbazine, levothyroxine, and CNS stimulants (eg, methylphenidate) can cause manic symptoms.

Mental Status Exam

General appearance: The patient appears excited, restless, hyperactive, and dressed in colorful or dramatic clothing. They may be engaging and entertaining, but may also be hostile and uncooperative.
Speech: Rapid rate, increased volume, increased quantity, and difficult to interrupt.
Mood: "Great."
Affect: Expansive, euphoric, labile at times with rapid shifts to irritability; sometimes alternating with intense dysphoria.
Thought process: Pressured, with flight of ideas.
Thought content: Grandiose delusions of great wealth and intelligence, feelings of having special powers, such as clairvoyance, or ideas of reference.
Perceptual: Auditory, visual, or command hallucinations may occur with psychotic features.
Suicidality: May be present, especially in mixed-manic states with depressive symptoms.
Homicidality: Typically denies.
Sensorium/cognition: Alert and oriented, with variable immediate and delayed recall, depending on the patient's ability to focus or cooperate. The patient may be easily distracted, with poor attention and concentration. Thinking is not concrete or abstract, but may be bizarre and incoherent at

times.
Impulse control: Impaired. The patient may be hypersexual and repeatedly attempt to touch the examiner.
Judgment: Impaired. Manic patients often do not understand how their symptoms affect behavior or other people.
Insight: Impaired. Patients may like the symptoms of mania and do not recognize the need for treatment.
Reliability: Limited. Patients experiencing manic episodes may not be able to give accurate information about past medical, psychiatric, personal, or substance-abuse histories.

Laboratory data: Complete blood count, chemistry, liver function tests, lipase, amylase, ceruloplasmin, vitamin B_{12}, vitamin B_3, RPR, thyroid function tests, and toxicology screen.

Diagnostic testing: Electroencephalography, computed tomography, magnetic resonance imaging.

Diagnosis: Axis I: Bipolar I disorder, manic episode, schizoaffective disorder, bipolar type.
Differential Diagnosis

Psychiatric: Bipolar II Disorder, cyclothymia, borderline personality disorder, substance-induced manic symptoms (eg, amphetamines, PCP), schizoaffective disorder, and delirium.

Medical: Hyperthyroidism, renal failure, vitamin B_3 deficiency (pellagra), vitamin B_{12} deficiency, carcinoid syndrome, and medication-induced mania (eg, antidepressants, amantadine, bromocriptine, corticosteroids, disulfiram, isoniazid, levodopa, procarbazine, levothyroxine, CNS stimulants).

Neurological: Huntington's disease, Wilson's disease, CNS infection, neoplastic disease, cerebrovascular accidents, head trauma, temporal lobe epilepsy, multiple sclerosis, and Pick's disease.

Bipolar I Disorder - Discussion

I. Epidemiology. Mania occurs in the context of bipolar I disorder and schizoaffective disorder, bipolar type. Bipolar I disorder affects approximately one percent of the population. It is equally prevalent in men and women, and symptoms typically begin late in adolescence. There is often a delay in the diagnosis of bipolar disorder because the disorder may initially present with depressive symptoms, and manic symptoms may not develop for many years.

II. Etiology. Bipolar disorder is associated with genetic factors, but the pattern of inheritance remains unclear. One proposed etiology is impaired regulation of the biogenic amines, particularly serotonin and norepinephrine.

III. Clinical evaluation

A. Mania is characterized by elevated mood and at least three of the following seven symptoms for a period of one week: inflated self-esteem, decreased need for sleep, pressured speech, racing thoughts, increased distractibility, increased goal-directed activity, and hedonism. Four symptoms are required for diagnosis if the mood is only irritable.

B. Acutely manic patients may be unreliable historians, and the diagnosis of mania is often made based on information from friends and family in combination with the patient's mental status exam.

C. The presence or history of one manic episode is sufficient to make the diagnosis of bipolar disorder, even in the absence of past depressive symptoms. There is no such entity as unipolar mania.

D. Throughout the course of bipolar disorder, a patient may cycle frequently between discrete episodes of mania and major depression (ie, rapid cycling), or in some instances, experience these episodes concurrently (ie, mixed state).

E. Psychotic features may occur in the context of a manic episode, and this is an important distinction between mania and hypomania. Hypomania is a less severe form of mania that does not occur with psychotic features and is consistent with a separate diagnostic entity called bipolar II disorder. Hypomania may eventually progress into mania.

IV. Treatment

A. Patients who present with manic symptoms may require inpatient hospitalization because they are a danger to themselves or others due to impulsive behavior and impaired judgment. Manic patients can be violent, especially on inpatient units.

B. Acute mania is treated with antipsychotic medication and benzodiazepines because these agents have sedative effects. Mood stabilizers, such as lithium, sodium divalproex, and carbamazepine, are started for long-term prophylaxis of mood cycling.

C. Psychoeducation, supportive therapy, and family psychotherapy also play important roles in helping patients and families develop insight and cope with chronic illness.

References, see page 92.

Psychosis - History Taking

History of present illness: Current symptoms, date of onset, duration, recent stressors, and degree of functional impairment. Symptoms of psychosis are often elicited by first asking, "Have you felt like your mind has been playing tricks on you?" Ask about unusual or odd experiences,

auditory, hallucinations, (including command hallucinations, number of voices the patient hears, and voices commenting or conversing). Ask the patient to describe where the voices are coming from (eg, inside or outside their head).

Ask about the presence of visual, tactile, and olfactory hallucinations. Assess delusional content, paranoid thinking, suspiciousness, fear, ideas of reference, ideas of influence, special powers, thought broadcasting, thought insertion, delusions of guilt or sin, grandiose delusions, somatic delusions, and magical thinking.

Ask about a history of violence or responding to command hallucinations. Assess disorganized behavior by asking about eating habits, recreational activities, social and sexual activity, and agitated behavior. Allow the patient to speak freely to assess the presence of thought disorders, such as circumstantiality, tangentiality, derailment, loosening of associations, word salad, or neologisms.

Ask the patient about negative symptoms such as anhedonia, apathy, and social withdrawal. Suicidal ideation, plans, and a history of suicide attempts should also be assessed. Ask about symptoms of clinical depression and mania to exclude schizoaffective disorder, major depression with psychotic features, or bipolar I disorder.

Past psychiatric history: Previous psychiatric diagnoses, symptoms of previous psychotic episodes, date of first psychiatric contact, and reasons for first hospitalization. Assess number of hospitalizations, duration of hospitalization, number per year, and whether hospitalizations tend to occur during a specific time of year. Previous treatments, medication history with duration and dosages, treatment adherence, and side effects from past medications: dystonia, tardive dyskinesia, parkinsonism, akathisia, and neuroleptic malignant syndrome. Ask about current psychiatric care, day treatment programs, and management by an intensive case manager or outpatient therapist.

Substance abuse history: Rule out substance-induced psychotic symptoms with questions about alcohol, amphetamines, cannabis, hallucinogens, cocaine, and PCP use. Withdrawal from substances, such as barbiturates and alcohol, can also cause psychotic symptoms.

Social history: Prenatal insults, childhood trauma or illness, social functioning, relationship history, level of education, job history, housing, and source of income. Assess the impact of psychotic symptoms on daily functioning.

Family history: Presence of psychotic disorders or odd and eccentric personality traits in family members, distant relatives, or other household members.

Past medical history: Psychotic symptoms can be caused by delirium, AIDS, systemic lupus erythematosus, Wernicke-Korsakoff syndrome, seizures, Parkinson's disease, dementias, cerebrovascular disease, CNS lesions, herpes encephalitis, neurosyphilis, head trauma, and Wilson's disease.

Medications: Ask about medical and psychiatric medications, dosages, adherence, and who administers the medication. Corticosteroids, anticholinergics, and levodopa can all cause psychotic symptoms.

Mental Status Exam

General description: Disheveled, poorly related, possible psychomotor agitation or retardation (including catatonia), guarded, suspicious, menacing, uncooperative at times; the patient may appear to be responding to hallucinations.
Speech: Normal rate, rhythm, and volume.
Mood: "Fine," "bad," or "scared."
Affect: Often blunted or flat.
Thought process: Illogical, tangential, with loosening of associations, poverty of speech (alogia).
Thought content: Paranoid delusions about family, friends, neighbors, coworkers, doctors, government agencies or strangers. Ideas of reference, thought insertion or withdrawal, and somatic, erotic, or grandiose delusions.
Perceptual: Hallucinations may be auditory, visual, olfactory, tactile, or gustatory, although auditory hallucinations are most common.
Suicidality: Suicide attempts occur more frequently in patients with psychotic disorders, and 10 percent of people with schizophrenia will eventually commit suicide.
Homicidality: Homicidal ideation directed towards objects of paranoia.
Sensorium/cognition: Alert and oriented; possible impairment in the ability to immediately repeat or recall words depending on the presence of distracting hallucinations or formal thought disorder. Poor concentration, no apparent language deficits, fair fund of knowledge and vocabulary. Thinking is usually concrete. The mini-mental state exam is not reliable in acutely psychotic patients.
Impulse control: Possibly poor impulse control (eg, lunges at security guard about whom patient has become paranoid).
Judgment: Impaired. The patient has a markedly altered sense of reality.
Insight: Limited. The patient does not understand why he has been brought to the hospital.
Reliability: May be significantly impaired. Corroborative data is usually helpful.

Laboratory data: Complete blood count, chemistry, liver function tests, thyroid function tests, vitamin B_{12} and folate levels; urinalysis with toxicology screen, blood alcohol level, HIV testing, RPR, and serum ceruloplasmin.

Diagnostic testing: Electroencephalography, computed tomography, or magnetic resonance imaging for new onset psychosis, Scale for the Assessment of Negative Symptoms (SANS), and the Scale for the Assessment of Positive Symptoms (SAPS).

Diagnosis: Axis I: Schizophrenia, brief psychotic, schizophreniform, schizoaffective, shared psychotic, and delusional disorders.

Differential Diagnosis for Psychosis:

Psychiatric: Major depression with psychotic features, bipolar I disorder, autistic disorder, obsessive-compulsive disorder (OCD), delirium, dementia, schizotypal, schizoid, borderline, and paranoid personality disorders, factitious disorder, substance-induced psychotic disorder, and malingering.

Medical: AIDS, B_{12} deficiency, Wernicke-Korsakoff syndrome, carbon monoxide or heavy metal poisoning, systemic lupus erythematosus, and Wilson's disease.

Neurological: Epilepsy, cerebral neoplasm, cerebrovascular disease, head trauma, herpes encephalitis, neurosyphilis, Creutzfeldt-Jakob disease, and normal pressure hydrocephalus.

Schizophrenia - Discussion

I. Epidemiology. Schizophrenia is the most common psychotic disorder, affecting one percent of the population. Men and women are equally affected. The typical age of onset for schizophrenia is in young adulthood, but men are initially affected earlier than women.

II. Etiology. A genetic basis for schizophrenia is widely accepted. The stress diathesis theory is the prevailing model, and it posits that schizophrenia results from an interaction between biologic vulnerability and environmental stress.

III. Clinical evaluation

A. The history of present illness should focus on specific symptoms, illness duration, prodromal signs, and premorbid functioning. There are no pathognomonic signs of schizophrenia, and the symptom presentations vary widely. Assessment of premorbid personality characteristics may reveal shy, withdrawn behavior, or social isolation during childhood.

B. The five main symptoms of schizophrenia are delusions, hallucinations, disorganized speech, disorganized behavior, and negative symptoms (ie, deficits in personal and social function). Two out of five symptoms for a duration of at least 6 months are required for diagnosis.

C. The difference between schizophrenia, schizophreniform disorder, and brief psychotic disorder is mainly in symptom duration. Schizoaffective disorder is diagnosed in the presence of psychotic symptoms *and* a prominent mood disturbance. Delusional disorder occurs in older patients and is characterized by non-bizarre delusions. Socio-occupational functioning in Delusional Disorder may not be impaired beyond the direct effect of the delusion itself. Shared psychotic disorder is rare and occurs in the context of a close relationship with another person who suffers from a known psychotic illness.

D. Psychotic symptoms may also occur in clinical depression and mania.

IV. Treatment

A. Patients with schizophrenia may require admission for suicidality, agitated behavior that is potentially dangerous, severe distress from their psychosis, or if they are unable to care for themselves.

B. Schizophrenia requires lifelong treatment with antipsychotic medication. Atypical antipsychotics, such as risperidone or olanzapine, are currently the first line of treatment.

C. Clozapine is reserved for treatment-resistant schizophrenia.

D. Day treatment programs, including psychosocial therapies, play a supportive role in the treatment of psychotic disorders.

References, see page 92.

Anxiety - History Taking

History of present illness: Current symptoms, time of onset, frequency, duration, symptom triggers, fears, worries, somatic complaints, obsessions, and compulsions. Ask about panic symptoms, such as palpitations, shortness of breath, feeling of choking, trembling, chest pain, sweating, nausea, dizziness, paraesthesias, derealization or depersonalization phenomena, and fear of losing control or dying.

Ask about agoraphobia and other avoidant behavior, irritability, phobias (eg, animals, heights, needles, performance, elevators). Screen specifically for obsessive-compulsive disorder (OCD) with questions about obsessions, such as fears of

contamination, pathological doubt, intrusive thoughts, and need for symmetry. Ask questions about accompanying compulsions, such as cleaning, hand washing, counting, checking, ordering, and compulsive slowness.

For posttraumatic and acute stress disorder, ask about exposure to a life-threatening event, intrusive recollections of the event, nightmares, avoidant behavior, decreased interest in activities, and hyperarousal with insomnia, hypervigilance, and startling easily. Assess comorbid depressive symptoms.

Past psychiatric history: Previous psychiatric diagnoses, panic attacks or phobias in the past, history of Tourette's disorder, or separation anxiety as a child. Assess history of psychiatric hospitalizations, psychotherapy, pharmacologic treatments, side effects, and adherence.

Substance abuse history: Amphetamines, cannabis, nicotine, and hallucinogens may produce symptoms of anxiety. Withdrawal from alcohol, opioids and benzodiazepines can also cause anxiety. Screen for comorbid alcohol, opioid, and prescription medication abuse and dependence.

Social history: Details of trauma history, physical abuse, sexual abuse, exposure to violence, disasters, or war.

Past medical history: Mitral valve prolapse, myocardial infarction, hypertension, asthma, COPD, carcinoid syndrome, hypoglycemia, hyperthyroidism, epilepsy, and cerebrovascular disease can all mimic or directly cause symptoms of anxiety. Huntington's disease and a history of head trauma increase the risk of OCD.

Medications: Aspirin, penicillin, antihypertensives, caffeine, sympathomimetics, anticholinergics, and theophylline may cause anxiety. Abruptly stopping antidepressant and anxiolytic medication may also cause anxiety. Antipsychotic medications may induce a state of restlessness known as akathisia, which appears similar to anxiety.

Mental Status Exam

General description: Restless, fidgeting, psychomotor agitation.
Speech: Rate may be increased, but with normal rhythm and volume.
Mood: "Scared," "nervous," "out of control."
Affect: Anxious, irritable, but congruent with stated mood.
Thought process: Pressured, may be more talkative than usual, ruminative, but linear and goal-directed.
Thought content: Preoccupied about somatic complaints, fearful of recurrent panic, phobia or obsessions; patient is afraid of what bad events may happen in the future.
Perceptual: No auditory, command auditory, or visual hallucinations.
Suicidality: May be present, especially with comorbid clinical depression; untreated anxiety is a risk factor for suicide.
Homicidality: Rare.
Sensorium/cognition: Alert and oriented, poor concentration, intact memory, no apparent language deficits or disturbance in abstract thinking, good fund of knowledge and vocabulary. The mini-mental state exam score is greater than 24.
Impulse control: Fair. No evidence that the patient is a danger to himself or others.
Judgment: Fair. Understands the nature and consequences of his illness.
Insight: Good, although the patient may place exaggerated emphasis on anxiety symptoms.

Reliability: Good. Symptoms are described consistently, and specific triggers for anxiety can often be clearly identified by the patient.

Laboratory data: Complete blood count, chemistry, thyroid function tests, liver function tests, urinalysis with toxicology screen and blood alcohol level, urine pregnancy test, calcium, vitamin B_{12} and folate levels.

Diagnostic testing: Electrocardiography, echocardiography, and chest x-ray.

Diagnosis: Axis I: Panic disorder, agoraphobia, social phobia, specific phobia, obsessive-compulsive disorder, posttraumatic and acute stress disorder, Generalized Anxiety Disorder.

Differential Diagnosis

Psychiatric: Adjustment disorder with anxiety, major depression, dysthymia, hypochondriasis, somatization disorder, separation anxiety disorder, substance intoxication or withdrawal, factitious disorder, avoidant, obsessive-compulsive, dependent, and borderline personality disorders.

Medical: Myocardial infarction, angina, hypertension, mitral valve prolapse, cardiac arrhythmias, asthma, chronic obstructive pulmonary disease, hyperthyroidism, hyperparathyroidism, carcinoid syndrome, and hypoglycemia.

Neurological: Epilepsy, cerebrovascular disease, vertigo, tumors, and head trauma.

Anxiety Disorders - Discussion

I. **Epidemiology.** Anxiety may be an appropriate and adaptive response to stress but is considered pathological when symptoms begin to impair functioning. Anxiety disorders are among the most common psychiatric diagnoses and typically begin in adolescence or young adulthood.

II. **Etiology.** The etiology varies according to the specific disorder, but a combination of increased sympathetic discharge, impaired regulation of serotonin, and classical conditioning (ie, specific stimuli become paired with anxiety responses) account for most symptom presentations.

III. **Clinical evaluation**

- **A.** Generalized anxiety disorder is characterized by at least six months of pervasive worry or concern in addition to symptoms of muscle tension, restlessness, irritability, insomnia, and difficulty concentrating.
- **B.** In order to diagnose panic disorder, the patient must experience panic attacks, anticipatory anxiety about having attacks, and subsequent avoidant behavior. Panic disorder may occur with or without agoraphobia. Panic attacks last between five and 20 minutes and are characterized by at least four of the following 13 symptoms: palpitations, shortness of breath, feelings of choking, paraesthesias, nausea, chest pain, sweating, trembling, chills or hot flushes, dizziness, fear of losing control, fear of dying, and derealization or depersonalization.
- **C.** Obsessive-compulsive disorder is characterized by recurrent and intrusive thoughts that cause anxiety (obsessions) and repetitive behaviors designed to relieve the anxiety (compulsions). Symptoms of OCD follow several patterns, such as obsessive fears of contamination and compulsive cleaning, need for symmetry and slowness, and pathological doubt and checking.

D. Specific phobias are focused on stimuli, such as animals or needles. Social phobia involves fears of humiliation and embarrassment in public.

E. Acute stress and posttraumatic stress disorders are also categorized as anxiety disorders and are reviewed in the following chapter.

IV. Treatment

A. Hospitalization is rarely required unless anxiety precludes patients from taking care of themselves (eg, agoraphobia), or unless there are other potentially dangerous comorbid psychiatric problems, such as clinical depression.

B. Pharmacotherapy consists of selective-serotonin reuptake inhibitors. Clomipramine, venlafaxine, nefazodone, mirtazapine, and buspirone are also effective. Benzodiazepines are a very effective short-term treatment, but may lead to symptom exacerbation, tolerance, and dependence over time.

C. Psychosocial therapies play a significant role in the treatment of anxiety disorders. Cognitive-behavioral therapy is effective in panic disorder, social phobia, and GAD. Behavioral therapy with techniques such as graded exposure, systematic desensitization, relaxation techniques, and hypnosis is used in OCD, specific phobia, stress disorders, and agoraphobia.

References, see page 92.

Acute Stress and Posttraumatic Stress - History Taking

History of present illness: Ask about a traumatic event witnessed or experienced directly; date of event, and duration of current symptoms. Assess symptoms of re-experiencing the event through nightmares, recurrent recollections, flashbacks, hallucinations, and illusions. Avoidant behavior of stimuli associated with the trauma, detachment from other people, decreased interest in activities, decreased libido, emotional numbing, and feeling of a foreshortened future.

Assess symptoms of increased arousal, such as, hyperactivity, irritability, decreased concentration, sleep abnormalities, and exaggerated startle response. Ask about associated symptoms such as survivor guilt, guilt about not preventing the traumatic experience, depression, anxiety, panic attacks, shame, anger, hostility, impulsivity, somatic symptoms, substance abuse, suicidal ideation, and self-injurious behavior.

Past psychiatric history: Major depression, panic disorder, agoraphobia, obsessive-compulsive disorder, and personality disorders occur with increased frequency in patients who experience posttraumatic stress disorders. Assess premorbid risk factors, such as borderline personality traits, history of childhood trauma, feeling that external events (rather than internal) control life changes, and rigid coping mechanisms.

Substance abuse history: Alcohol and drug abuse are very common comorbid conditions in posttraumatic stress disorder. Symptoms of substance intoxication or withdrawal may mimic posttraumatic stress symptoms.

Social history: History of exposure to trauma, terrorism, war, disasters, rape, burglary, physical abuse, and sexual abuse. Evaluate current social support and recent stressful life changes.

Family history: Psychiatric illness or history of trauma in first-degree family members.

Past medical history: Childhood illness, history of head trauma, seizure disorder, and chronic medical illness.

Medications: All psychiatric, medical, over-the-counter, or alternative treatments.

Mental Status Exam

General appearance: Restless, "on edge," hypervigilant, or withdrawn with poor eye-contact secondary to feelings of humiliation.
Speech: Rate and volume may be increased or decreased, rhythm is typically normal.
Mood: "Scared," "depressed," "nervous."
Affect: Irritable, anxious, or dysphoric.
Thought process: Linear and goal-directed.
Thought content: Ruminations of guilt, rejection, and recurrent thoughts about traumatic event.
Perceptual: Olfactory or other hallucinations reminiscent of event, illusions, and flashbacks.
Suicidality: Passive ideation to end suffering, and, less commonly, an active plan.
Homicidality: Denies. But patient may have non-specific homicidal ideation towards those perceived to be responsible for the trauma (eg, rapist).
Sensorium/cognition: Alert and oriented, but memory, concentration, and attention could be impaired; the mini-mental state exam score remains greater than 24.
Impulse control: Possibly impaired. The patient may storm out of the interview when an unpleasant question is posed.
Judgment: Fair. The patient is able to stop himself from hurting other people.
Insight: Good. The patient understands the nature of symptoms and underlying illness.
Reliability: Fair. The patient may overemphasize the extent of the symptoms.

Laboratory data: Complete blood count, chemistry, urine pregnancy test, urine toxicology screen, and blood alcohol level.

Diagnosis:
Axis I: Posttraumatic stress disorder and acute stress disorder.

Differential diagnosis: Head trauma, post-concussion syndrome, seizure disorder, acute stress disorder, adjustment disorder, dissociative disorders, major depression, dysthymia, phobias, generalized anxiety disorder, panic disorder, borderline personality disorder, substance-related disorders, factitious disorder, and malingering.

Posttraumatic Stress Disorder-Discussion

I. Epidemiology. Posttraumatic stress disorder (PTSD) occurs following a traumatic event involving the risk of death or physical injury that is either witnessed or experienced directly. PTSD may occur in up to 30 percent of people who experience trauma and is common in combat veterans and victims of assault, rape, or terrorism.

II. Etiology. PTSD is caused by the traumatic stressor. However, biological and psychosocial factors also contribute because only a minority of people who experience trauma develop PTSD. Patients with borderline personality traits or a past history of childhood trauma are more likely to experience symptoms following a traumatic event.

III. Clinical evaluation

A. Clinical features of PTSD follow three

major symptom patterns: re-experiencing the event, avoidant behavior, and increased arousal. Nightmares and flashbacks are common symptoms that are typically accompanied by anxiety, avoiding stimuli associated with the traumatic event, hypervigilance, insomnia, exaggerated startle response, and impaired concentration.

B. Dissociative symptoms may also occur. Patients may experience amnesia or feel as though they have stepped outside of their bodies and exist in a state of unreality.

C. The onset of PTSD symptoms may occur at any time following the traumatic event. Acute stress disorder is diagnosed when symptoms begin within four weeks of the event and last less than four weeks.

III. Treatment

A. Patients with PTSD may require inpatient hospitalization for stabilization in cases of suicidal risk or if functioning has become severely impaired.

B. Pharmacotherapy includes the use of sedatives and hypnotics for the acute symptoms of anxiety and sleep disturbance. Clonidine, tricyclic antidepressants, and cyproheptadine may specifically reduce nightmares. Long-term management is usually achieved with selective-serotonin reuptake inhibitors, but imipramine and amitriptyline have also been used. Clonidine may be an effective adjunctive treatment to reduce sympathetic arousal.

C. Psychosocial treatment involves encouraging the patient to discuss the details revolving around the event, supportive therapy, and cognitive therapy. A focus on facilitating improved coping mechanisms and behavior therapy with relaxation training may also be helpful.

References, see page 92.

Cognitive Impairment - History Taking

History of present illness: Begin with questions about current symptoms and duration. Determine acute or gradual onset of symptoms. If cognitive impairment is worsening, assess gradual or stepwise decline. Ask questions about memory loss, memory for time, place, person, recent memory, and remote memory. Language disturbance (aphasia), motor activity (apraxia), recognition (agnosia), and executive functioning should be assessed in addition to memory loss (amnesia). Ask about word finding difficulties, activities of daily living (eg, dressing, tying shoes, domestic chores), naming objects, recognizing faces, planning, organizing, and concentrating.

Ask about diurnal variation of symptoms (sundowning), wandering, impulsivity, anger, irritability, agitation, apathy, depressed mood, delusional thinking, and perceptual disturbance. Rule out delirium by assessing causative precipitants, symptom acuity, level of consciousness, and attention.

Past psychiatric history: Clarify a history of depressive symptoms to consider pseudodementia. Ask about previous amnestic episodes, psychotic symptoms in the past, and a history of transient cognitive impairments associated with medical illness or surgery.

Substance abuse history: Alcohol intoxication *and* withdrawal may cause cognitive impairment, amnesia, and psychotic symptoms. Long-term, continuous alcohol abuse can cause dementia.

Ask about extent of use, withdrawal symptoms, shakes, seizures, delirium tremens, and blackouts (anterograde amnesia). Benzodiazepines can mimic or exacerbate symptoms of dementia by causing confusion, disinhibition, and amnesia.

Social history: Ask about housing, nursing home care, supervised living, and the assistance of a home-health aide. Assess extent of family support, marital status, children, income, and safety in the home.

Family history: Alzheimer's disease, Huntington's disease, and Parkinson's disease have a pattern of familial inheritance and may be associated with symptoms of dementia.

Past medical history: Assess history of cerebrovascular disease, cardiovascular disease, demyelinating disorders, head trauma, systemic lupus erythematosus, CNS infection, liver disease (hepatic encephalopathy), and renal disease (uremia). Ask about risk factors associated with multi-infarct dementia: hypertension, hyperlipidemia, diabetes, smoking, obesity, atrial fibrillation, and hypercoagulable states.

Medications: Obtain details of medications with dosages and duration of treatment. Ask about over-the-counter medications, alternative treatments, and dietary supplements. Medications that can cause symptoms of dementia include anticholinergics, antihypertensives, and anticonvulsants. Toxic levels of medications can cause delirium (eg, anticholinergics, anticonvulsants, antipsychotics, antihypertensives, steroids, sedatives, hypnotics).

Mental Status Exam

General appearance: Disheveled, angry and uncooperative, poorly related, inattentive, limited eye contact, and confused.
Speech: Normal rate, rhythm, and volume in general, but possibly dysarthric if associated with cerebrovascular disease.
Mood: "Fine," "depressed."
Affect: Dysphoric, irritable, and labile with intermittent hostility.
Thought process: Illogical, tangential, difficulty following train of thought, perseverative at times.
Thought content: Paranoid delusions, such as people stealing from the patient or impersonating family members, and confabulation.
Perceptual: Auditory, visual, and command hallucinations are possible.
Suicidality: Varies with level of self-awareness and presence of psychosis or affective symptoms.
Homicidality: May occur in association with paranoia.
Sensorium/cognition: Non-delirious, demented patients should be alert, but may not be oriented to place or time. Registration and recall may be impaired; concentration is impaired, word finding difficulties are common, and apraxia affects ability to follow commands. On the clock-drawing task, patients may bunch numbers together, skip numbers, or indicate the time incorrectly. The mini-mental state score will be less than 24 in demented patients.
Impulse control: Limited. Patients have aggressive outbursts with difficulty controlling anger.
Judgment: Impaired. Patients are socially inappropriate and potentially disinhibited.
Insight: Insight is characteristically absent, and patients tend to minimize symptoms.
Reliability: Impaired. Family members and caregivers should be interviewed for information.

Laboratory data: Complete blood count, chemistry, toxicology screen, urinalysis, thyroid function tests, vitamin B_{12} and folate levels, RPR, thiamine level, homocysteine level, and HIV testing.

Diagnostic testing: Chest x-ray, computed tomography, magnetic resonance imaging, Boston Naming Test (language), Weschler memory scale, Weschler Adult Intelligence Scale, digit span test (attention and recall), Wisconsin Card Sorting Test (executive function), Trail Making A and B (cognitive processing speed), Halstead Battery Category Test (abstraction), Hachinski ischemia score, and Delirium Rating Scale.

Diagnosis: Axis I: Delirium, dementia, depression (pseudodementia), amnesia.

Differential Diagnosis:
Psychiatric: Amnesia, depression, mania, schizophrenia, and normal aging.

Medical: Alzheimer's disease, Lewy Body disease, Pick's disease, Parkinson's disease, Huntington's disease, Wilson's disease, vascular dementia, demyelinating disorders, traumatic brain injuries, cerebral neoplasm, hydrocephalus, CNS infection, heavy metal poisoning, uremia, hepatic encephalopathy, hyperthyroidism, hypercalcemia, vitamin B_{12} and folate deficiency.

Dementia - Discussion

I. Epidemiology. Alzheimer's disease is responsible for approximately half of all cases of cognitive impairment in the elderly. Vascular dementia causes 15 to 20 percent cases of cognitive impairment in the elderly. Alzheimer's and vascular dementia together account for the vast majority of dementia cases. However, dementias, such as Lewy Body disease, Pick's disease, Parkinson's disease, HIV-related dementia, and Huntington's disease, should be considered in the differential diagnosis. Dementia affects up to 50 percent of the population over age 85.

II. Etiology

- **A. Alzheimer's disease** is a result of neuropathological changes that include amyloid protein deposition. Approximately 40 percent of all patients have a family history of the disease.
- **B. Vascular dementia** is caused by multiple infarctions due to atherosclerotic plaques and thromboemboli occluding cerebral vessels.
- **C. Delirium** is associated with medical illness and surgical procedures. Patients with underlying dementia and the elderly are at the greatest risk of developing delirium.

III. Clinical evaluation

- **A.** The hallmark of dementia is memory loss (amnesia). Patients may wander in their neighborhood, pace around their house, and have difficulties with everyday tasks, such as dressing or tying shoelaces (apraxia). They may fail to recognize objects or family members (agnosia). Language disturbance can cause word-finding difficulties (aphasia), and planning and organizational abilities are often impaired (executive functioning).
- **B.** Alzheimer's disease is more likely than with other causes of dementia to cause personality changes and aggressive, irritable, sarcastic, or apathetic behavior.
- **C.** In evaluating a patient with cognitive impairment, the primary task is to rule out delirium and reversible causes of dementia. The onset and progression of cognitive decline provide important clues to the diagnosis. Patients with Alzheimer's dementia typically demonstrate a gradual, progressive decline in cognitive functioning.
- **D.** Vascular dementia shows a more stepwise decline in functioning where each infarct causes abrupt impairment. Delirium causes

a sudden onset of mental status changes with altered level of consciousness and a rapidly fluctuating course, although the symptom presentation is similar to dementia.

IV. Treatment

A. Agitated behavior is the most common reason for admission for patients with dementia or delirium.

B. Alzheimer's disease is treated with cholinesterase inhibitors for symptomatic improvement and to possibly slow cognitive decline.

C. Vascular dementia is treated by reducing risk factors, such as hypertension, hyperlipidemia, diabetes, smoking, and obesity.

D. Atypical antipsychotics are used to treat delusions, hallucinations, and agitated behavior associated with dementia. Delirium requires treatment of the underlying etiology.

E. Supportive psychotherapy may help patients and their families to cope with the stress associated with loss of autonomy, declining health, and impaired cognitive functioning.

References, see page 92.

Delirium - History Taking

History of present illness: Assess impaired consciousness; fluctuating levels of consciousness, arousability, ability to sustain attention, ability to focus, and reduced clarity of awareness of the environment. Ask about current symptoms, nature of onset, causative precipitants, and duration; delirium develops over a short period of time and symptoms fluctuate over the course of the day. Assess cognitive changes, such as, memory impairment, disorientation, and language disturbance.

Ask about abnormalities of mood (eg, anger), perception (eg, visual hallucinations), and behavior (eg, agitation). Assess psychomotor disturbance, such as hyperactivity with increased startle response, flushing, sweating, tachycardia, nausea, vomiting, and hyperthermia. Hypoactivity may manifest with slowed reaction time, catatonia, and depression.

Language disturbance may include rambling, changes in the flow of speech, or incoherent speech. Ask about sleep disturbance; insomnia, nightmares, hypnopompic and hypnagogic hallucinations, reversal of the sleep-wake cycle, daytime drowsiness, and exacerbation of symptoms at night (ie, sundowning).

Past psychiatric history: Ask about previous delirious episodes, psychotic symptoms in the past, and a history of transient cognitive impairments associated with medical illness or surgery.

Substance abuse history: Alcohol intoxication and withdrawal may cause cognitive impairment, delirium, amnesia, and psychotic symptoms. Ask about all substances used, extent of use, and history of withdrawal symptoms. Alcohol dependence increases the risk of developing delirium.

Social history: Ask about housing, employment, extent of family support, marital status, and children.

Family history: Ask about family history of psychiatric illness and dementia. Delirium does not occur more frequently among family members unless the underlying etiology is heritable.

Past medical history: Assess history of seizure disorder, neoplasm, infection, vascular disease, or trauma. Ask about cardiovascular disease, liver disease (hepatic encephalopathy), and renal disease (uremia).

Medications: Obtain details of medications, with dosages and duration of treatment. Ask about over-the-counter medication and alternative treatments. Toxic levels of anticholinergics, anticonvulsants, antipsychotics, antihypertensives, steroids, lithium, and sedatives can cause delirium.

Mental Status Exam

General appearance: Inattentive, limited eye contact, confused.
Speech: Normal rate, rhythm, and volume.
Mood: "Angry," "afraid."
Affect: Dysphoric, irritable, and labile.
Thought process: Tangential, incoherent, or irrelevant speech.
Thought content: Paranoid delusions without systematized content.
Perceptual: Auditory and visual hallucinations are most common in delirium.
Suicidality: Varies according to the presence of psychosis and affective symptoms.
Homicidality: May occur in association with paranoia.
Sensorium/cognition: Not alert, disoriented, with fluctuating level of consciousness. Impaired memory and concentration, poor attention and limited problem-solving abilities.
Impulse control: Limited. Patients may be aggressive with difficulty controlling anger.
Judgment: Impaired. Patients may be inappropriate and disinhibited.
Insight: Fair. Patients realize the nature of their symptoms.
Reliability: Limited. Attention and thinking are typically too impaired to give a reliable history.

Laboratory data: Complete blood count, chemistry, thyroid function tests, RPR, HIV testing, urinalysis, toxicology screen, serum medication levels, blood and urine cultures if indicated, vitamin B_{12}, thiamine, and folate levels, and lumbar puncture with CSF examination if indicated.

Diagnostic testing: Electroencephalography, chest x-ray, computed tomography, and Delirium Rating Scale.

Diagnosis: Axis I: Delirium due to a general medical condition, substance intoxication delirium, substance withdrawal delirium, delirium due to multiple etiologies, and delirium not otherwise specified

Differential Diagnosis
Psychiatric: Dementia, substance intoxication or withdrawal, depression, schizophrenia, brief psychotic disorder, mania, and dissociative disorders.

Medical: Epilepsy, head trauma, infection, medication toxicity (eg, anticholinergics, anticonvulsants, antipsychotics, antihypertensives, sedatives, lithium, steroids), heavy metal poisoning, endocrine dysfunction, hepatic encephalopathy, uremic encephalopathy, carbon dioxide toxicity, hypoxia, cardiac failure, vitamin deficiencies (eg, thiamine, B12, folate), and electrolyte imbalance.

Table 6. Delirium vs. Dementia

Delirium	Dementia
Clouding of consciousness	No changes in consciousness

Significant attention deficit	Less attention deficit
Abrupt onset (hours to days)	Gradual onset (weeks to years)
Transient duration	Chronic duration
Fluctuating symptom severity	Gradual worsening of symptoms

Delirium - Discussion

I. Epidemiology

A. Up to one-third of patients on surgical wards, medical wards, or intensive care units experience delirium over the course of their hospital admission.

B. Patients with underlying dementia and the elderly are at the greatest risk of developing delirium. Other risk factors include preexisting brain damage, a history of delirium, alcohol dependence, recent surgery, and malnutrition.

C. The presence of delirium increases mortality.

II. Etiology

A. The most common causes of delirium are central nervous system disease, systemic disease (eg, cardiac failure), and substance or medication intoxication or withdrawal.

B. Causes of postoperative delirium include pain, electrolyte imbalance, infection, fever, and blood loss.

C. Acetylcholine has been hypothesized to be the major neurotransmitter involved in delirium, and the reticular formation may be the primary neuroanatomical area.

III. Clinical evaluation

A. The hallmark of delirium is clouding of consciousness accompanied by a reduced ability to sustain attention. Patients typically have impaired cognitive function with memory deficit and disorientation. Perceptual and psychomotor disturbances also occur.

B. Physical signs of delirium may include flushing, pallor, sweating, tachycardia, nausea, and vomiting.

C. Neurological signs of delirium may include dysphasia, tremor, asterixis, ataxia, and incontinence. Symptoms tend to develop abruptly over several hours and may last days to weeks. Symptom severity may fluctuate over the course of the day, ranging from severe impairment and disorganization to periods of lucidity.

D. Delirium should always be suspected in patients on medical or surgical wards with psychiatric symptoms that are new or abrupt in onset.

IV. Treatment

A. Agitated behavior is the most common reason for admission or consultation in patients with delirium. Delirium requires treatment of the underlying etiology. Medicating symptoms should usually be avoided. In anticholinergic toxicity, physostigmine may be used in repeated doses.

B. High-potency antipsychotics with low anticholinergic side effects (eg, haloperidol) are used for psychotic symptoms.

C. Patients must be carefully monitored to avoid potential harm from falls, agitated behavior, or other accidents. Maintaining an environment that minimizes stimulation may reduce agitation.

References, see page 92.

Suicidal Ideation - History Taking

History of present illness: The interview should begin with questions about current symptoms, duration, and date of onset. Ask about recent life changes, interpersonal stress, marital conflict, illness in the family, or legal problems. Assess suicide potential by addressing intent, plans, means, and perceived consequences. Distinguish between passive and active suicidal ideation in assessing intent by asking about specific plans, the ability to resist suicidal impulses, and what factors influence the degree of determination, such as, children, spouse, or work.

Assess the lethality of the plan, and ask about any preparations made, such as writing a will or giving away personal belongings. Always ask about the availability of weapons or medication to assess means. Ask about the perceived consequences of suicide and evaluate the patient's beliefs about a desirable outcome, such as financial benefit to the family, or reunion with a deceased loved one. Negative consequences of suicide such as emotional pain to the family should be discussed. Ask about anything the patient may feel they have to live for, and assess evidence of plans for the future, such as a trip to see children, or concern that hospitalization may interfere with an important event.

Evaluate concurrent depressive symptoms, feelings of hopelessness, substance abuse, anxiety, and psychosis. Ask about command auditory hallucinations. Consider features of personality disorders in the assessment of suicidal ideation, such as poor impulse control, mood lability, unstable self-esteem, unstable relationships, and other cluster B personality traits.

Past psychiatric history: Ask about all past psychiatric symptoms, diagnoses, treatments, and previous suicide attempts. Suicide is more likely to occur in patients just recovering from suicidal depression or in the few weeks to months following discharge from the hospital. Patients with a history of suicide attempts are at greater risk. Suicide is most commonly associated with major depression, but also occurs with significantly increased rates in bipolar disorder, schizophrenia, substance abuse disorders, borderline personality disorder, antisocial personality disorder, cognitive disorders, organic mental disorders, anxiety disorders, and adjustment disorders.

Substance abuse history: Ask about all substances used. Alcohol abuse and dependence is most commonly associated with suicide, especially in the presence of comorbid psychiatric disorders. Heroin dependence is also associated with increased rates of suicide. Ask about availability of lethal amounts of the substance abused and method of use. Substance abuse can sometimes be perceived as a form of suicidal behavior, and accidental overdose is a frequent cause of death in substance abusers.

Social history: Ask about marital status, living situation, social support, family conflict, employment, legal trouble, financial trouble, illness in the family, recent loss of a loved one, and feelings of social isolation. Divorce, unemployment, living alone, poor social support, and loss of a loved one are significant risk factors for suicide.

Family history: A history of suicide in the family increases the risk for suicide. Also ask about family history of psychiatric illness and treatment.

Past medical history: Comorbid medical illness increases the risk of suicide. Epilepsy, multiple sclerosis, cardiovascular disease, Huntington's disease, dementia and AIDS are all associated with depression and increase the risk of suicide.

Other medical problems that occur with mood disorders also increase suicidal risk and include: Cushing's disease, anorexia nervosa, porphyria, cerebrovascular disease, and cirrhosis.

Medications: Ask about all medications, especially ones potentially lethal in overdose, such as barbiturates, anticonvulsants, and tricyclic antidepressants.

Mental Status Exam

General appearance: Withdrawn, uncooperative, with poor eye-contact.
Speech: Not spontaneous, soft, slow, with paucity of speech.
Mood: "Depressed," "sad," "angry," "hopeless," "worthless"
Affect: Constricted, dysphoric, congruent
Thought process: Linear, but may have increased response latency.
Thought content: Possible ruminations of guilt or obsessive thoughts about suicide methods.
Perceptual: Possible auditory hallucinations with commands to "just do it" or "end it."
Suicidality: Positive ideation with plans to jump in front of traffic, history of attempts via overdose; the patient may be unable to commit to contacting someone if feeling suicidal, or he may be unable to agree not to hurt himself (ie, commit to safety).
Homicidality: Denies
Sensorium/cognition: Memory and concentration may be impaired. Perform the mini-mental state exam in patients with suspected dementia or cognitive impairment related to depression.
Impulse control: Variable. A history of poor impulse control increases the risk of suicide.
Judgment: Impaired. The patient may not understand how their behavior will affect family and friends.
Insight: Fair. The patient wishes to die but may not understand the significance of the underlying illness.
Reliability: Fair; reliability is crucial in assessing commitment to safety.

Laboratory data: Complete blood count, chemistry, urinalysis with toxicology screen and blood alcohol level, and urine pregnancy test.

Diagnostic testing: Testing should be done according to the differential diagnosis and depending on symptom presentation.

Differential diagnosis:
Axis I: Major depression, bipolar I disorder, schizophrenia and other psychotic disorders, alcohol and other substance abuse disorders, dementia, adjustment disorder, panic and other anxiety disorders, and anorexia nervosa.
Axis II: Borderline and antisocial personality disorders.
Axis III: Neoplastic disease, epilepsy, multiple sclerosis, Huntington's disease, AIDS, Cushing's disease, cirrhosis, and porphyria.

Suicidal Ideation - Discussion

I. Epidemiology

A. Suicide is the eighth-leading cause of death in the United States. Approximately 12 people per 100,000 commit suicide, and rates among adolescents have increased significantly in recent decades. Women are more likely to attempt suicide, and men are more likely to complete suicide.

B. Suicide is most frequently associated with major depression, and approximately 15 percent of patients will eventually commit suicide. One-third of people with schizophrenia will attempt suicide and an estimated 10

percent will complete the act.

C. Risk factors for suicide include depression, increased age (>45), alcohol dependence, prior suicidal behavior, medical or psychiatric illness, recent divorce or loss of a loved one, unemployment, and family history of suicide

II. Etiology. Suicide is associated with a combination of psychological and biological factors. Freud believed that suicide represented aggression turned inward. Other theories include ideas of self-punishment, escape from suffering, or reunion with the dead. Reduced central serotonin is associated with suicidal behavior.

III. Clinical evaluation

A. Suicidal ideation must be thoroughly assessed in the mental status exam. Patients should be questioned about their specific plans and availability of means.

B. A previous history of attempts and a family history of suicide greatly increase risk. Feelings of hopelessness are often a reliable predictor of suicide. The majority of patients will reveal thoughts of suicide prior to attempts.

IV. Treatment

A. Suicidal ideation typically requires inpatient hospitalization unless patients can reliably commit to safety. A specific plan, lack of social support, hopelessness, and previous suicide attempts should lower the threshold for inpatient admission.

B. Underlying medical and psychiatric illness must be appropriately addressed.

References, see page 92.

Malingering - History Taking

History of present illness: Current symptoms, duration, date of onset. Virtually all symptoms may be feigned, but amnesia, mental retardation, cognitive disorders, psychosis, depression, and posttraumatic stress symptoms are the most common. Assess degree of intentionality, degree of symptom exaggeration, and degree of actual impairment (if any). Identify external incentives, such as avoidance of military duty, work, social responsibility, or jail.

Also consider issues of secondary gain, such as financial gain, medications (eg, benzodiazepines, methadone), hospital admission for free room and board, or refuge from the police. In malingered amnesia, first exclude other possible causes of amnesia, such as head injury, alcohol abuse, seizure disorders, true psychosis, and dissociative disorders. Ask about the nature of amnesia, such as localized, selective, or generalized. Consider timing of onset and whether amnesia has a self-serving component. Patients with malingering amnesia often have selective amnesia with opportune timing.

In malingered mental retardation, assess for discrepancies between level of educational or work achievement and reported intellectual functioning, and distinguish between patterns of prior and current test performance.

In malingered cognitive disorders, assess for impaired social functioning. Malingerers are rarely able to feign thought process disturbance, such as perseveration, and typically are unaware of the social impairment that accompanies most cognitive disorders.

In malingered psychosis, assess adherence to a known clinical picture, detail the nature of symptoms and onset, effect on behavior, and thought process disturbance. Patients attempting to malinger psychosis often claim abrupt onset, with

symptoms that do not adhere to any known disorder. Patients also tend to think that the more bizarre their behavior, the more convincing they are. Unlike true psychosis, malingerers may be eager to call attention to their symptoms, and their behavior is not consistent with delusional content. Malingerers may not know the subtle characteristics of hallucinations beyond reporting "hearing voices" (see Table 7).

In malingered depression, ask about diurnal variation, irritability, decreased libido, and anhedonia. Malingerers are less likely to be aware of the more subtle symptoms of depression or that depressive withdrawal extends to social and recreational activities as well as work.

Past psychiatric history: Ask about past psychiatric diagnoses, treatment, and hospitalizations. Malingerers are more likely to have antisocial, borderline, histrionic, and narcissistic personality traits.

Substance abuse history: Ask about substances abused, and consider the possibility that patients are drug-seeking. People with substance dependence may seek hospital admission by feigning psychiatric symptoms.

Social history: Ask about employment and source of income to assess possible issues of secondary gain. Ask about a history of legal problems, arrests, or current warrants. Malingering is more common in military and prison populations.

Family history: Ask about family history of psychiatric illness, substance abuse, and suicidality. There is no evidence of familial patterns in malingering.

Past medical history: Ask about medical problems and rule-out the possibility that complaints may be related to an underlying medical illness.

Medications: Ask about prescription, over-the-counter, and alternative medications.

Mental Status Exam

General appearance: Calm, but may be uncooperative or overly dramatic. Trunk and extremities may show marked restlessness as compared to facial expression.
Speech: Slow to fast rate. Malingered mania may be accompanied by rapid speech that tires easily as the interview progresses. Volume also varies.
Mood: "Depressed."
Affect: Congruent to reported mood.
Thought process: Linear. Thought disorder is very difficult to imitate. Malingerers may repeat questions to give themselves time to think of an answer and often say, "I don't know."
Thought content: Delusions may be claimed to have sudden onset, and malingerers often think that the more bizarre the delusion, the more likely they are to be believed. Delusional content is more likely to be paranoid or grandiose, but is rarely self-deprecating. Behavior is not likely to be consistent with delusions.
Perceptual: Unlike in true psychotic disorders, malingered hallucinations are often continuous, rather than intermittent, are not associated with delusions, and are vague in their content. Patients report an inability to ignore the voices and do not have strategies to diminish them, unlike in true psychosis.
Suicidality: Suicidal thoughts and plans are frequently reported in attempts to gain hospital admission.
Homicidality: Homicidal ideation is also a frequent presenting complaint, and malingerers may threaten homicide.

Sensorium/cognition: Memory, concentration, and intellectual impairment are often feigned; malingerers may give approximate answers to simple questions (eg, 2 + 2 =5).
Impulse control: Potentially impaired; attempts to challenge or confront the patient may be met with anger or threats.
Judgment: Fair. The degree of impairment in judgment will vary on an individual basis.
Insight: Intact. The patient understands that symptoms are being intentionally produced.
Reliability: Limited. Malingerers are likely to contradict themselves in their symptom reporting.

Laboratory data: Complete blood count, chemistry, urine toxicology screen.

Diagnostic testing: Skull x-ray to rule out head trauma, magnetic resonance imaging, and neuropsychological testing as needed. Other tests may include a polygraph to assess physiological stress and the Minnesota Multiphasic Personality Inventory (MMPI) to detect inconsistent answers.

Diagnosis: Axis I: Malingering

Differential diagnosis: Conversion disorder, other somatoform disorders, factitious disorder, and Ganser's syndrome.

Table 7. Malingered vs. True Hallucinations

Malingered Hallucinations	True Hallucinations
Continuous	Intermittent
Originating from inside the head	Originating from outside the head
Vague or inaudible content	Relatively clear and specific content
Not associated with delusional content	Associated with delusional content
Stilted language is common	Stilted language is rare
Unable to use strategies to diminish voices	Able to use strategies to diminish voices
Voices persist throughout sleep	Sleep provides a respite from the voices
Commands are always obeyed	Commands are rarely obeyed
Visual hallucinations are common	Visual hallucinations are rare
Visual hallucinations may be seen in black and white	Visual hallucinations are seen in color
Visual hallucinations may change if eyes are open or closed	Visual hallucinations rarely change if eyes are open or closed

Malingering - Discussion

I. Epidemiology

A. Malingering is estimated to occur in approximately one percent of mental health patients, five percent in the military, and between ten and 20 percent among criminal defendants.

B. Adults with antisocial personality disorder and children with conduct disorder are more likely to lie about symptoms for external incentives. The other cluster B personality disorders are also more frequently associated with malingering.

II. Etiology

A. Malingering is the intentional production of false or grossly exaggerated symptoms that is motivated by external incentives.

B. The most frequent reasons for malingering are avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, and obtaining drugs. Because of its association with antisocial personality disorder, some theories propose hypoarousability as a predisposing factor.

III. Clinical features

A. Malingering has an understandable motive that can be identified only after true medical or psychiatric illness has been ruled out. Malingering is suspected when the clinical presentation is characterized by symptoms that are vague and overly dramatized and not consistent with known clinical conditions.

B. These patients often display a marked discrepancy between claimed disability and objective findings. Findings may appear consistent with self-inflicted injury, and the history may reveal past episodes of injury. Restlessness, fidgeting, and lack of cooperation during an interview may indicate malingering.

C. There may be a significant discrepancy between the rehearsed and calm facial expression of a malingerer as compared to their body movement and behavior.

D. Extending the duration of an interview may facilitate the diagnosis by exhausting the patient's ability to malinger. Malingerers may experience difficulty suppressing correct answers to questions.

E. Malingering should always be suspected whenever specific external incentives, such as avoiding work or the military, are present.

IV. Management

F. Malingerers should not be admitted to the hospital unless true illness cannot be ruled out. They should be approached with clinical neutrality and confronted only after careful assessment.

G. If malingering is confirmed, external incentives should be addressed and alternate means of achievement explored. Comorbid psychiatric illness should be assessed and treated.

References, see page 92.

Dramatic or Emotional Personality Disorders - History Taking

History of present illness: Current symptoms, duration, date of onset, psychosocial stressors, associated distress, and functional impairment. Borderline personality disorder should be assessed by asking about interpersonal relationships, dependency, feelings of emptiness or abandonment, impulsivity, depressed mood, suicidal ideation, irritability, anger, hostility, anxiety, mood swings, poor self- image, impaired sense of identity, fear of being alone, self-mutilation, and dissociative symptoms, such as derealization and depersonalization.

Histrionic personality disorder should be assessed by asking about need for attention and flirtatious and seductive behavior. Narcissistic personality disorder is suggested by a sense of self-importance, grandiosity, self-entitlement, arrogance, self-esteem, and empathy. Antisocial personality disorder should be assessed by asking about impulsivity, deceitfulness, irritability, aggressiveness, disregard for the safety and rights of other people, and lack of remorse. Evaluate for comorbid depressive symptoms and substance abuse or dependence.

Past psychiatric history: Past hospitalizations, diagnoses, treatments, and outpatient follow-up. History of suicide attempts or self-mutilation; ask the patient if they feel calm or relieved following self-injurious behavior. Depression, anxiety disorders, somatization disorder, and substance abuse occur with increased frequency in patients with cluster B personality disorders. Suspected antisocial personality disorder should be assessed by asking about a history of conduct disorder symptoms beginning before age 15 and a history of attention-deficit/hyperactivity disorder.

Substance abuse history: Alcohol, cocaine, heroin, marijuana, hallucinogens, amphetamines, sedatives, hypnotics, anxiolytics, and analgesics. Substance abuse is frequently seen in patients with borderline and antisocial personality disorders. Alcohol abuse in particular is associated with antisocial personality disorder.

Social history: History of abandonment, physical or sexual abuse, neglect, rape, and exposure to substance abusing parents. Current living situation, employment, relationships, sexual history, and assessment of promiscuity. If antisocial personality disorder is suspected, a history of legal problems, arrests, incarceration, and current warrants should be assessed.

Family history: Substance abuse and major depressive disorder occur with increased frequency among first-degree relatives of patients with borderline personality disorder. Antisocial traits may also be more likely to occur in family members of patients with antisocial personality disorder.

Past medical history: Perinatal complications, childhood history of illness, history of head trauma, brain damage, infection, and current medical problems.

Medications: All prescription and over-the counter medications.

Mental Status Exam

General appearance: Well-dressed, well-groomed, in colorful clothing, seductive, excessively ingratiating, well-related, and without signs of psychomotor retardation or agitation.
Speech: Variable volume, dramatic, alternates between slow and rapid rates.
Mood: "Very bad," "depressed."
Affect: Labile, expansive, irritable, and inappropriate at times.
Thought process: Linear. Goal-directed, but vague.
Thought content: Patients may be preoccupied with somatic complaints and perceived medical problems, such as pain and dehydration.
Perceptual: Patients may endorse auditory, visual, or command auditory hallucinations, the details of which are difficult to elicit. Patients may also report the feeling of being outside their body (depersonalization).
Suicidality: Passive (no plan), active (with a specific plan), or vague suicidal ideation that is difficult to characterize.
Homicidality: Vague homicidal thoughts may occur in borderline personality disorder, but thoughts may be much more explicit in antisocial personality disorder.
Sensorium/cognition: Alert and oriented, intact memory, good concentration, thinking is concrete, but with appropriate fund of knowledge. The mini-mental state exam is usually normal.
Impulse control: Limited. Patients may attempt to hurt themselves during the course of the interview, particularly if they perceive that their symptoms are not being taken seriously.
Judgment: Limited. The patient does not understand how behavior affects other people.
Insight: Limited. The patient does not recognize the nature of the illness and may relate symptoms to environmental stressors alone.
Reliability: Poor. History is vague, and symptom reporting is inconsistent.

Laboratory data: Complete blood count, chemistry, thyroid function tests, RPR, urine toxicology screen, blood alcohol level, and pregnancy test.

Diagnostic testing: Projective psychological testing, such as the Rorschach and the Thematic Apperception Test, Hamilton Rating Scale for Depression, and the CAGE questionnaire are often positive.

Diagnosis: Axis II: Borderline, histrionic, narcissistic, and antisocial personality disorders.

Differential diagnosis: Bipolar I and II disorders, major depressive disorder, generalized anxiety disorder, somatoform disorders, substance-induced mood disorder, adjustment disorder, and posttraumatic stress disorder.

Dramatic or Emotional Personality Disorders - Discussion

I. **Epidemiology.** The most frequently encountered personality disorders on inpatient psychiatric units fall into the dramatic and emotional cluster, also called cluster B. The cluster B personality disorders are borderline, histrionic, antisocial, and narcissistic personality disorder. Cluster B personality disorders are more common in women with the exception of antisocial personality disorder.
II. **Etiology.** Personality disorders are likely caused by an interaction between biological predisposition and environmental influence. Antisocial and borderline personality disorders

may demonstrate familial inheritance. Histrionic and borderline personality disorders are associated with a history of physical or sexual abuse.

III. Clinical evaluation

A. Personality disorders are diagnosed on Axis II. They are difficult to assess in the context of acute Axis I pathology, and clinicians tend to defer their diagnosis until acute issues have resolved.

B. Personality disorders are defined by a pervasive pattern of behavior that is persistent over time, deviates from cultural standards, and causes significant distress *or* functional impairment to the patient.

C. Borderline personality disorder patients exhibit a clinical tetrad of labile affect, unstable self-image, poor impulse control, and volatile interpersonal relationships. Dissociative phenomena of depersonalization and derealization may occur and contribute to feelings of identity confusion. Patients may report that the pain of self-mutilation serves to bring them back to reality during a state of identity diffusion or dissociation.

D. Histrionic personality disorder patients have shallow emotional responses, but express themselves in a dramatic fashion. They constantly require attention and may misinterpret superficial relationships as being more intimate than they are in reality.

E. Antisocial personality disorder patients are often manipulative, deceitful, and have a lack of remorse about their behavior. These patients had conduct disorder as a child, and frequently have a history of violence and other criminal activity.

F. Narcissistic personality disorder patients appear extremely self-entitled with a grandiose sense of importance, but actually suffer from low self-esteem and are extremely sensitive to criticism. Narcissistic patients are preoccupied with selfish pursuits and may be unrealistically ambitious.

IV. Treatment

A. Patients with personality disorders may require inpatient hospitalization for suicidality or severe impairment in functioning.

B. Treatment usually consists of long-term psychotherapy. Psychopharmacologic treatment of personality disorders is limited, although antidepressants such as selective-serotonin reuptake inhibitors may be used to treat comorbid depression, anxiety, and impulsivity. Mood stabilizers and antipsychotics are used for mood lability and behavioral control.

C. Prognosis varies individually according to level of functioning and the presence of social support, but these disorders are usually very difficult to treat.

References, see page 92.

Developmental Delay - History Taking

History of present illness: Ask about current symptoms, duration, age of onset, and recent stressors or changes in the patient's life. Assess language development, social interaction, reciprocal play, eye contact, stereotypic behaviors, such as rocking and spinning, preoccupation with inanimate objects, compulsive behavior, and rigid adherence to specific routines.

Motor incoordination, hand wringing, and apraxic gait in females may suggest Rett's disorder. Associated symptoms may include agitated behavior, temper tantrums, low frustration tolerance, poor impulse control, hyperactivity, affective lability, and self-injurious behavior (eg, biting, scratching, head banging).

Past psychiatric history: Previous hospitalizations, past diagnoses, outpatient treatment and medications. Ask specifically about comorbid obsessive-compulsive symptoms, depressed or irritable mood, attention deficit, hyperactivity, and Tourette's disorder (eg, motor and vocal tics).

Substance abuse history: Substance abuse is rare in young children, but screening questions should be asked. Always consider accidental ingestion.

Social history: Family relationships, current living situation, and social relationships at day care, school, or home. Recent stressors, such as divorce of parents, exposure to marital conflict, changing school, moving, and birth of a sibling.

Developmental history: Perinatal history, specific trauma or stressors, developmental milestones, school achievement, and special education.

Family history: Psychiatric, neurological, and developmental disorders in relatives. Mental retardation, pervasive developmental disorders, learning disorders, delayed language development, and impaired social interaction may occur more frequently in family members.

Past medical history: Perinatal complications, respiratory distress syndrome, neonatal anemia, congenital rubella, phenylketonuria, fragile X syndrome, tuberous sclerosis, seizures, and neurological lesions all occur with greater frequency in children with developmental disorders.

Medications: Prescribed medications and over-the-counter.

Mental Status Exam

General appearance: Inattentive, uncooperative, disengaged, with poor eye contact; stereotypic movements, such as hand wringing, rocking in place, and grimacing.
Speech: Possibly incomprehensible, peculiar rhythms, babbling, screeching, and non-spontaneous.
Mood: Apathetic, easily irritable.
Affect: Constricted, shallow, and unpredictably labile.
Thought process: Possibly incoherent, with echolalia and perseveration.
Thought content: No delusions present.
Perceptual: The presence of hallucinations should raise suspicion of childhood onset schizophrenia, not pervasive developmental disorders.
Suicidality: The patient usually denies suicidal thoughts, although self-injurious behavior may appear when the patient feels frustrated during the course of the examination.
Homicidality: Denies.

Sensorium/cognition: Alert. Cognitive abilities may be impaired by mental retardation, concrete thinking, egocentricity, increased distractibility, and short attention span.
Impulse control: Limited. The patient becomes easily angered, with temper tantrums and self-injurious behavior, such as head banging.
Judgment: Limited. The patient lacks understanding of behavior's consequences and how it affects others.
Insight: Limited. The patient does not understand the nature of his illness.
Reliability: Limited. Interviewers must rely on family, teachers, and other caregivers for information.

Laboratory data: Complete blood count, chemistry, urinalysis, screening for phenylketonuria and other inborn errors of metabolism, chromosomal analysis, thyroid function tests, and lead testing.

Diagnostic testing: Autism Diagnostic Interview (ADI), Vineland Adaptive Behavior Scale, Childhood Autism Rating Scale, Autism Behavior Checklist, neuropsychological testing audiometry, magnetic resonance imaging, and electroencephalography.

Diagnosis: Axis I: Autistic disorder, childhood disintegrative disorder**,** Asperger's disorder**,** and Rett's Disorder**.**

Differential diagnosis: Mental retardation with behavioral symptoms, learning disorders, communication disorders (eg, mixed receptive-expressive language disorder), selective mutism, psychosocial deprivation, childhood onset schizophrenia, and congenital deafness.

Pervasive Developmental Disorders - Discussion

I. **Epidemiology.** The four pervasive developmental disorders are autistic disorder, Rett's disorder, childhood disintegrative disorder, and Asperger's disorder. Autistic disorder is the most common and affects approximately 1.7 out of 1000 children, occurring more frequently in boys. It is typically diagnosed by the age of three, and affected children tend to suffer a chronic, lifelong course.

II. **Etiology.** The etiology of autism is genetic in origin, but with an unclear mode of transmission. There is significant evidence linking autism to heritable neurological disorders, perinatal complications, and mental retardation.

III. **Clinical evaluation**

- **A. Autistic disorder** is characterized by the clinical triad of impaired language development, impaired social interaction, and limited behavioral repertoire. The most common initial feature is delayed language development. Audiometry should be performed to rule out deafness.
- **B.** Approximately two-thirds of patients with autistic disorder have mental retardation, and one-third may develop a seizure disorder. Comorbid obsessive-compulsive symptoms are common in autistic disorder. Patients tend to become preoccupied with inanimate objects, such as metal, and they may become easily frustrated or anxious if ritualistic behaviors are interrupted.
- **C. Rett's disorder** occurs only in girls. Rett's disorder is characterized by symptoms of autism in addition to progressive neurological signs, such as apraxia, ataxia, and stereotypic movement. Patients with Rett's disorder eventually become wheelchair bound and lose all language ability.
- **D. Childhood disintegrative disorder** is characterized by normal development for two years, followed by a loss of acquired language, impaired social interaction, and limited behavioral repertoire.
- **E. Asperger's Disorder** is a less severe form of autism where language development remains intact.

IV. **Treatment**

- **A. Inpatient hospitalization** may be required for agitated or self-injurious behavior. People with pervasive developmental disorders may require residential care with full-time supervision.
- **B. Behavioral therapy** and educational methods are focused on increasing social interaction, reducing odd behavior, and developing language. Improvement may occur over time.
- **C. Pharmacotherapy** is useful for symptomatic management. Selective serotonin reuptake inhibitors are used for impulsivity, irritability, and compulsive, ritualistic behavior. Clonidine is used for hyperactivity, Antipsychotics may effectively reduce agitation, aggression, and self-injurious behavior.

References, see page 92.

Attention-Deficit and Hyperactivity - History Taking

History of present illness: Current symptoms, duration, date of onset, identifiable stressors. Determine in which environments symptoms occur (eg, school, home). Ask about inattention, hyperactivity, and impulsivity. Assess symptoms of difficulty listening and following instructions, distractibility, forgetfulness, constant need for attention, irritability, talking excessively, fidgeting, and interrupting.

Motor tics, vocal tics, blinking, raising eyebrows, neck twisting, grunting, belching, and shouting. Ask about anxiety symptoms, such as persistent worry, reluctance to attend school, excessive fear of being alone, nightmares, difficulty sleeping away from home, phobias, obsessions, compulsions, and panic. Ask about the presence of somatic symptoms, such as nausea and vomiting. Assess the presence of depression, irritability, suicidal ideation, and violence.

Past psychiatric history: Previous psychiatric diagnoses. Obsessive-compulsive symptoms, depressive symptoms, history of mood lability, irritability, learning disorders, anxiety, Tourette's disorder, and conduct disorder are all common comorbid conditions. Ask about past hospitalizations, medication, and outpatient psychiatric treatment.

Substance abuse history: Alcohol, marijuana, cocaine, heroin, hallucinogens, amphetamines (eg, speed, crystal meth, ecstasy, crank), and cigarettes.

Social history: Family relationships, adoption, divorce, marital conflict, domestic violence, physical abuse, sexual abuse, and emotional neglect. Grade in school, school performance, special education, social relationships with peers, and sexual behavior.

Family history: Psychiatric illness in family members, such as substance abuse, conduct disorder, antisocial personality disorder, depression, bipolar disorder, learning disorders, ADHD. Tic disorders occur with increased frequency in family members of children with ADHD.

Past medical history: Prenatal exposure to toxins, alcohol, cigarette smoke, lead, cocaine, hypoxia. Low birth weight, childhood lead exposure, pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS), hyperthyroidism, seizure disorder, and head trauma.

Medications: CNS stimulants, antidepressants, carbamazepine, divalproex, benzodiazepines, phenobarbital, theophylline, and caffeine can cause symptoms of attention deficit and hyperactivity.

Mental Status Exam

General appearance: Restless, fidgeting, uncooperative, poor eye-contact, easily distracted.
Speech: Decreased volume, increased rate, mumbling rhythm.
Mood: "Fine" or "depressed."
Affect: Irritable, dysphoric, but appropriate.
Thought process: Linear and goal-directed, but with some difficulty following a coherent train of thought due to problems concentrating and distractibility.
Thought content: No active delusional content; may express frustration, fear or dislike for school or social situations.
Perceptual: Denies hallucinations or illusions.

Suicidality: No active suicidal ideation.
Homicidality: Denies homicidal ideation.
Sensorium/cognition: Alert and oriented, intact memory, impaired concentration, no apparent language deficits. Thinking may be concrete.
Impulse control: Patients may get up frequently during the interview and even walk away.
Judgment: Fair. Age appropriate.
Insight: Limited, due to young age.
Reliability: Limited. Patient inconsistently reports symptoms.

Laboratory data: Complete blood count, chemistry, thyroid function test, zinc protoporphyrin (ZPP) to detect lead exposure, pregnancy test, and urine toxicology screen.

Diagnostic testing: Neuropsychological testing, Conners Hyperactivity Scale, and Achenbach Child Behavior Checklist.

Diagnosis: Axis I: Attention Deficit/Hyperactivity Disorder.

Differential Diagnosis

Psychiatric: Conduct Disorder, oppositional defiant disorder, bipolar disorder, mental retardation, learning disorders, anxiety disorders, substance abuse, major depression, motor compulsions associated with obsessive-compulsive disorder, Tourette's disorder, physical or sexual abuse, separation anxiety disorder, normal hyperactivity, and normal oppositional behavior.

Medical: Hyperthyroidism, substance-induced (eg, amphetamines, pseudoephedrine, barbiturates, benzodiazepines, carbamazepine, theophylline, caffeine), lead poisoning, teratogenic effects of alcohol, cocaine, lead, and cigarettes, malnutrition, streptococcal infection, and Wilson's disease.

Neurological: Seizure disorder, brain damage, and central nervous system infection.

Attention-Deficit/Hyperactivity Disorder - Discussion

I. **Epidemiology**. Attention-deficit/hyperactivity disorder (ADHD) is a common illness that accounts for up to half of child psychiatry outpatient visits and inpatient hospitalizations. This disorder occurs more frequently in boys than girls, and prevalence estimates range from 3 to 10 percent of school-age children.

II. **Etiology.** The etiology of ADHD is unclear, but both genetic and environmental influences have contributing roles. Recent attention has been focused on the specific roles of dopamine, serotonin, glutamate, GABA, and norepinephrine.

III. **Clinical evaluation**

   A. **The diagnosis of ADHD** requires at least six symptoms of inattention and/or hyperactivity for at least six months. ADHD is usually diagnosed by five years of age, and symptoms must occur before the age of seven. Symptoms must also occur in at least two settings, such as at school *and* at home.

   B. **Other psychiatric disorders** that are easily mistaken for ADHD include conduct disorder, oppositional defiant disorder, learning disorders, posttraumatic stress disorder, Tourette's disorder, major depression, and bipolar disorder. These disorders must first be excluded because treatment varies dramatically, and because the psychostimulants used to treat ADHD may

significantly exacerbate symptoms of other disorders.

IV. Treatment

A. Inpatient admission may be required for agitated or aggressive behavior. Neuropsychological testing is often required to rule out an underlying learning disorder. Family members, caretakers, school personnel and pediatricians should be interviewed.

B. Treatment of ADHD consists of psychostimulants for inattention, clonidine for hyperactivity, selective-serotonin reuptake inhibitors for impulsivity, and antipsychotics to target aggressive symptoms.

C. Psychosocial therapies include individual psychotherapy and behavior modification techniques that help the child to reduce anxiety and improve self-esteem.

References, see page 92.

Disruptive Behavior - History Taking

History of present illness: Current symptoms, date of onset, duration, psychosocial stressors. Aggression towards people, fighting, bullying, weapon use, stealing, sexual assault, destruction of property, and fire setting. Theft, lying, cheating, rule violations, running away from home, ignoring parental curfews, and school truancy.

General defiance of authority figures, temper tantrums, frequent arguing, and blaming others for misbehavior. Ask about comorbid psychotic symptoms, such as auditory hallucinations or paranoid delusions. Assess symptoms of depression and mania to rule out a comorbid mood disorder.

Past psychiatric history: Previous psychiatric diagnoses, past hospitalizations, medications, and outpatient psychiatric treatment. Attention deficit, hyperactivity, hostility, impulse control problems, depressive or manic episodes, panic attacks, phobias, learning disorders, communication disorders, developmental disorders, and mental retardation may all occur with increased frequency in patients with conduct disorder or oppositional defiant disorder.

Substance abuse history: Substance abuse is frequently seen with Conduct Disorder. Ask about alcohol use, marijuana, cocaine, heroin, amphetamines, barbiturates, and pain medication.

Social history: Family relationships, income**,** adoption, foster care, divorce, domestic violence, physical or sexual abuse, and neglect. Gang involvement, legal history; arrests, incarceration, and juvenile detention. School level, performance, attendance, and special education.

Family history: Antisocial personality disorder, conduct disorder, substance abuse, depression, bipolar disorder, ADHD, learning disorders, and schizophrenia all occur with greater frequency in family members of children with conduct disorder. Ask about alcohol and other substance abuse in family members.

Past medical history: Perinatal complications, head trauma, seizures, past illness, and allergies.

Medications: Include all psychiatric, general, and non-prescription medications.

Mental Status Exam

General appearance: Suspicious, uncooperative, hostile, and poorly related.
Speech: Normal rate, rhythm, and volume.
Mood: "Fine," "good," or "angry."
Affect: Dysphoric, irritable, but congruent and full-range.
Thought process: Linear and goal-directed.
Thought content: Delusional thinking, such as paranoid ideation, may occur in severe cases. The patient may be demeaning or challenging toward interviewer.
Perceptual: Hallucinations are unlikely.
Suicidality: No active suicidal ideation elicited.
Homicidality: Denies homicidal ideation and may be flippant or dismissive when questioned about violence history.
Sensorium/cognition: Alert and oriented, but cognitive abilities may be impaired by mental retardation, learning disorders, or attention deficit/hyperactivity disorder. Thinking is concrete.
Impulse control: Impaired. The patient may demonstrate destructive or threatening behavior.
Judgment: Limited. The patient lacks understanding of how his behavior affects others.
Insight: Limited. The patient may deny all symptoms and not recognize the presence of a problem.
Reliability: Limited. The patient minimizes symptoms and lies about past behavior.

Laboratory data: Complete blood count, chemistry, thyroid function tests, pregnancy test, and urine toxicology screen.

Diagnostic testing: Neuropsychological testing, electroencephalography, and the Achenbach Child Behavior Checklist.

Diagnosis: Axis I: Conduct disorder, oppositional defiant disorder.

Differential diagnosis: Bipolar disorder, major depression, dysthymia, ADHD, mental retardation, learning disorders, impulse control disorders, substance-induced behavioral symptoms, and normal oppositional behavior.

Conduct Disorder - Discussion

I. Epidemiology. Conduct disorder is the most common reason for an inpatient hospitalization or outpatient visits in children and adolescents. It is estimated to be present in more than half of all juvenile delinquents and incarcerated youth. Conduct disorder is more prevalent in boys, and it is usually diagnosed before 13 years old.

II. Etiology. Biopsychosocial factors play a significant causative role in conduct disorder. Aggressive and violent behavior in general may be associated with decreased serotonin metabolite (5-HIAA) in cerebrospinal fluid. Oppositional behavior may be normal and adaptive, but may also occur as a pathological entity and possible precursor to conduct disorder. Conduct disorder greatly increases the risk of developing antisocial personality disorder.

III. Clinical evaluation

A. The hallmark characteristic of conduct disorder is disruptive behavior that violates the rights of others and persists for at least 12 months. Oppositional defiant disorder is a less severe form of conduct disorder defined as a recurrent pattern of defiant and hostile behavior towards authority figures. In oppositional defiant disorder, behavior does not violate the rights of others, and is not associated with legal problems.

B. While there is clear genetic transmission of aggressive and violent tendencies, these

behaviors usually occur in the context of strict or punitive parenting styles, poverty, abuse, divorce, or substance abuse among family members.

C. **Early symptoms of bipolar disorder** may be initially misdiagnosed as conduct disorder. In severely violent cases of conduct disorder, the possibility of psychotic symptoms must also be assessed.

IV. Treatment

A. **Inpatient hospitalization** becomes necessary if patients pose a danger to themselves or other people, including family members and peers. Formal psychiatric evaluation and clearance may also be required before the child is allowed to return to school.

B. **Treatment for disruptive behavior** revolves around firm limit-setting and establishing predictable consequences for breaking rules. The family must be involved, and parents should be taught techniques to facilitate appropriate behavior.

C. **Psychotherapy with behavioral training** is effective at reducing impulsive and aggressive behavior. Selective serotonin reuptake inhibitors may be effective for impulsivity and irritability. Antipsychotics, mood stabilizers, or clonidine are used for aggression.

References, see page 92.

Eating Disorders - History Taking

History of present illness: Ask questions about current symptoms, duration, date of onset, precipitants, and recent dieting. Ask the patient about their perception of body weight and self-image, preoccupation with food, dieting, food rituals, fear of weight gain, and actual weight loss. Amenorrhea, binge-eating behavior, vomiting or purging, dental caries, gastrointestinal distress, abuse of laxatives, diuretics, enemas, appetite suppressants, and excessive exercise.

Assess comorbid obsessive-compulsive symptoms, such as fear of contamination, checking, perfectionism, and need for control. Impulse control problems, stealing, self-mutilation, suicide attempts, sexual promiscuity, and substance abuse. Ask about depressive symptoms, suicidality, anxiety symptoms, somatic complaints, and sleep disturbance.

Past psychiatric history: Past hospitalizations, medications, and outpatient treatment. Previous episodes of binge-eating or purging behavior, previous weight loss episodes, history of depression, mood lability, past suicide attempts, obsessive-compulsive behavior, and impulse control problems.

Substance abuse history: Amphetamines, alcohol, cocaine, heroin, and marijuana. Ask about medications, such as sedatives, hypnotics, anxiolytics, analgesics, diuretics, enemas, ipecac, and laxatives.

Social history: Family relationships, domestic conflict, parenting styles, school achievement, school truancy, stealing, peer relationships, and sexual maturity. Attempt to gauge degree of independence, separation from parents, and perceived societal pressure to be thin.

Family history: Anorexia, bulimia, clinical depression, and obsessive-compulsive disorder are more

likely to occur in family members of patients with eating disorders.

Past medical history: Ask about a history of malignancy. Assess medical complications related to weight loss and purging activity; cardiac arrhythmias, amenorrhea, cold intolerance, edema, osteoporosis, gastric and esophageal erosion, cardiomyopathy secondary to ipecac toxicity, seizures, salivary gland enlargement, and dental caries.

Medications: Ask about psychiatric, medical, over-the-counter, and alternative medications.

Mental Status Exam

General appearance: Cachectic, with lanugo hair, orange colored skin, evasive, potentially hostile, uncooperative, and child-like.
Speech: Normal rate, rhythm, and volume.
Mood: "Fine."
Affect: Irritable, dysphoric, inappropriate at times, unconcerned, and dismissive or minimizing of serious symptoms.
Thought process: Linear and goal-directed.
Thought content: Preoccupied about body weight and image, fearful of gaining weight, obsessional or bizarre thinking revolving around food; patients may be convinced that they are overweight despite significant weight loss.
Perceptual: No auditory or visual hallucinations.
Suicidality: Suicide occurs more frequently in patients with eating disorders, and suicidal ideation must be thoroughly assessed.
Homicidality: Denies.
Sensorium/cognition: Cognition may be affected by weight loss, difficulty concentrating and fatigue, although most patients are alert and oriented, with intact memory and concentration. Language deficits or disturbance in abstract thinking are usually not present.
Impulse control: Limited. Binge-eating and purging behavior persists despite consequences.
Judgment: Limited. Weight loss continues despite medical complications.
Insight: Limited. Patients may deny all symptoms or the presence of a problem.
Reliability: Limited. Patients are often extremely secretive and do not fully disclose extent of symptoms.

Laboratory data: Complete blood count, chemistry, amylase, thyroid function tests, cholesterol, liver function tests, carotene level, pregnancy test, and urine toxicology screen.

Diagnostic testing: Height and weight measurement, dexamethasone-suppression test, and electrocardiography.

Diagnosis: Axis I: Anorexia nervosa and bulimia nervosa**.**

Differential diagnosis: Clinical depression, obsessive-compulsive disorder, psychotic disorders with delusional thinking revolving around food, borderline personality disorder with binge eating, somatization disorder, body dysmorphic disorder, Klüver-Bucy syndrome, Kleine-Levin syndrome, anorexia and weight loss associated with medical illness or malignancy.

Anorexia Nervosa and Bulimia Nervosa - Discussion

I. **Epidemiology.** Eating disorders typically first present during adolescence. They occur more frequently in women and are associated with significant morbidity and mortality secondary to

medical complications from weight loss and purging activity.

II. Etiology. The onset of anorexia or bulimia may be the result of difficulty adjusting to developmental changes of puberty and adolescence. In anorexia, starvation may be an effort by patients to control their bodies in response to overly controlling parents or the lack of a sense of autonomy. In bulimia, patients have a distorted body image and are frequently responding to societal pressures to be thin.

III. Clinical evaluation

A. The history should assess the full extent of symptoms despite the tendency for these patients to remain extremely secretive about their eating behavior.

B. Patients with eating disorders have disturbed eating behavior, a preoccupation with food, excessive concern about body weight, and a distorted body image.

C. Anorexia nervosa is characterized by refusal to maintain body weight above 85 percent of ideal, and lack of menstruation for at least three consecutive cycles.

D. Patients with bulimia nervosa binge eat and experience a loss of control over eating behavior, but maintain normal body weight.

IV. Treatment

A. Hospitalization may be required in patients with eating disorders for medical stabilization of electrolyte imbalance, dehydration, cardiac arrhythmias, or gastrointestinal complications.

B. After medical stabilization and restoration of nutritional status, patients are typically treated with a combination of psychotherapy and pharmacotherapy.

C. Cognitive behavioral therapy is effective in the treatment of eating disorders. Although anorexia nervosa is typically resistant to pharmacotherapy, bulimia nervosa may respond to antidepressant treatment even in the absence of depressive symptoms.

References, see page 92.

Substance Use - History Taking

History of present illness: The date of first and last use of the substance should be defined. Determine the frequency and patterns of use, amount of substance used; daily, weekly, monthly. Longest period of sobriety, route of administration, circumstances of use, triggers, and psychosocial stressors. Failure to fulfill obligations at home, work, or school; substance-related legal problems, and substance use in situations that are dangerous (eg, driving). Screening for alcohol abuse should be accomplished by asking about feeling the need to Cut down, becoming Annoyed by people who criticize the alcohol use , Guilt about drinking, and Eye openers to steady nerves in the morning (CAGE questionnaire).

If substance dependence is suspected, ask about the need for increasing amounts of the substance to produce intoxication (tolerance) and withdrawal symptoms. For alcohol withdrawal, ask about shakes, seizures, psychotic symptoms, and orientation. For opioid withdrawal, ask about dysphoria, nausea, vomiting, muscle aches, lacrimation, rhinorrhea, diarrhea, yawning, and insomnia.

For cocaine withdrawal, ask about anxiety, irritability, dysphoria, and insomnia. Sedative, hypnotic, and anxiolytic withdrawal may include tremors, insomnia, nausea, vomiting, anxiety, agitation, hallucinations, and seizures. Barbiturate abuse

should be carefully assessed because withdrawal is potentially fatal.

Question the patient and family members about behavioral changes, such as mood lability, aggressiveness, impulsivity, anxiety, irritability, sexual dysfunction, and impaired judgment. Substance abuse may also induce delirium, dementia, mood disorders, anxiety disorders, psychosis, amnesia, and sleep disorders.

Past psychiatric history: Past history of substance abuse, substance abuse treatment programs, medications, hospitalizations, past psychiatric diagnoses and treatment. Mood disorders, anxiety disorders, antisocial personality disorder, and borderline personality disorder occur with increased frequency in people with substance abuse disorders. Suicide is more frequent in people with substance abuse disorders. Substance abuse increases the risk of violence towards others. A history of attention-deficit/hyperactivity disorder and conduct disorder increases the risk of developing an alcohol-related disorder.

Substance abuse history: Ask about all substances used: alcohol, cocaine, amphetamines, heroin, marijuana, hallucinogens, benzodiazepines, and analgesics.

Social history: Living situation, employment, level of education, history of violence or criminal activity, physical or sexual abuse history.

Family history: Alcohol and substance-related disorders in first-degree relatives, family history of suicide and psychiatric illness.

Past medical history: Ask about medical complications from alcohol abuse, such as liver disease, gastritis, peptic ulcer disease, pancreatitis, cardiomyopathy, hypertension, nutritional deficiencies, and neuropathy. Assess physical signs of alcoholism, such as varices, hepatosplenomegaly, ascites, gynecomastia, and spider nevi. Complications from cocaine use, such as ulceration of the nasal septum, cardiac arrhythmias, and seizures. Complications from intravenous drug use, such as HIV, hepatitis, cellulitis, or osteomyelitis.

Medications: All medications including prescription and over-the-counter. Medication toxicity may mimic the symptoms of substance intoxication.

Mental Status Exam of the Intoxicated Patient

General appearance: Disheveled, poorly groomed, malodorous; may appear older than stated age, restless with mild shaking of the hands, gait is ataxic, and breath may smell of alcohol.
Speech: Slurred rhythm, increased volume, normal rate.
Mood: "Depressed."
Affect: Constricted to the dysphoric range, anxious, but appropriate.
Thought process: Circumstantial, gives irrelevant answers to questions, and words are sometimes incomprehensible.
Thought content: Paranoid ideation and ideas of reference occur. Patients may be dismissive of concerns about their drug use.
Perceptual: Depending on the level of intoxication or extent of withdrawal, patients may have auditory, visual, or tactile/olfactory hallucinations.
Suicidality: Substance abuse increases suicidal risk, so ideation and plans need to be assessed.
Homicidality: Possible homicidal ideation with plans that vary in specificity.
Sensorium/cognition: Inconstant alertness with variable degrees of orientation to place and time, poor concentration, poor registration and recall.

The patient may refuse to cooperate with a mini-mental state exam, and cases of alcoholic dementia may show scores less than 24.
Impulse control: When intoxicated, behavior may be aggressive and unpredictable.
Judgment: Impaired. There is often a lack of regard for how substance abuse affects family members and friends.
Insight: Limited. The patient does not recognize the substance abuse as a problem and relates difficulties to environmental stressors or "depression."
Reliability: Poor. There are frequent inconsistencies in the patient's story and symptom reporting.

Laboratory data: Complete blood count, chemistry, liver function tests, coagulability panel, amylase, lipase, cholesterol, triglycerides, B_{12} and folate level, blood alcohol level, and urinalysis with toxicology screen.

Diagnostic testing: CAGE Screening Questionnaire, Michigan Alcoholism Screening Test (MAST), Alcohol Use Disorders Identification Test (AUDIT), chest x-ray, and electrocardiogram.

Diagnosis: Axis I: Substance-related dependence, abuse, intoxication, withdrawal, delirium, dementia, amnestic disorder, psychotic disorder, mood disorder, and anxiety disorder, sexual dysfunction, and sleep disorder.

Differential Diagnosis: Alcohol-related disorders, amphetamine- related disorders, caffeine-related disorders, cannabis-related disorders, cocaine-related disorders, hallucinogen-related disorders, inhalant-related disorders, nicotine-related disorders, opioid-related disorders, phencyclidine-related disorders, sedative-, hypnotic-, or anxiolytic-related disorders, and polysubstance dependence.

Alcohol Abuse and Dependence - Discussion

I. Epidemiology. Alcohol is the most commonly abused substance in the United States. Approximately 20 percent of men and 10 percent of women have abused alcohol at some point in their lifetime, and dependence may develop in up to half of these cases.

II. Etiology. Alcohol-related disorders are thought to result from a multiplicity of factors, including biological predisposition, parent or peer influences, and underlying comorbid psychiatric illness.

III. Clinical evaluation

A. The clinical features of substance abuse are a maladaptive pattern of use that leads to significant impairment. Substance abusers are unable to fulfill work or personal obligations; they continue to use the substance in situations where it is physically dangerous; they have substance-related legal problems, and continue to use despite resultant interpersonal problems.

B. Substance abuse is defined as substance dependence when tolerance and withdrawal symptoms develop. Tolerance occurs when the user requires increasing amounts of the substance in order to become intoxicated.

C. Withdrawal is characterized by physiological symptoms that develop upon cessation of use. The initial signs of alcohol withdrawal are sweating and tachycardia. Tremors or "shakes," seizures, and auditory and tactile hallucinations (formication) may also occur within the first 48 hours of alcohol cessation.

D. Alcohol withdrawal delirium (delirium tremens) may present two to three days

after cessation, but patients are at risk for up to one week. Delirium typically occurs only in people who have abused alcohol heavily for many years.

E. Other symptoms of substance dependence include taking larger amounts of a substance than intended, persistent failed efforts to cut down, and spending an enormous amount of time trying to obtain the substance.

IV. Treatment

A. Patients with acute alcohol intoxication may require inpatient admission to prevent the development of seizures and delirium tremens, to treat dehydration, monitor suicidality, or to treat psychotic symptoms. Inpatient admission is also considered when outpatient detoxification has failed.

B. Benzodiazepines are used for withdrawal prophylaxis and acute management of seizures.

C. Patients are hydrated if necessary and thiamine is given to prevent the development of Wernicke's Encephalopathy. Long-term inpatient rehabilitation and ongoing outpatient substance-abuse counseling are required to prevent relapse.

References, see page 92.

Dissociation - History Taking

History of present illness: Current symptoms, duration, date of onset, sudden vs. gradual onset of symptoms, potential triggers, and associated distress. Ask about losing time, memory gaps, blackouts, forgetfulness, accumulating possessions without remembering how they were acquired. Ask the patient if he has ever been told about out-of-character behavior, or if he has ever found himself in places without knowing how he arrived. Dissociative Amnesia is assessed by asking about episodic memory loss, memory loss for specific intervals of time, or for personal information. Consider whether amnestic events are of a stressful or traumatic nature.

Dissociative Fugue is assessed by asking about recent travel and identity confusion. If Dissociative Identity Disorder is suspected, ask about another person existing inside the patient, voices coming from inside, and other people taking control of the patient. Also in dissociative identity disorder, ask about memory loss for childhood events, flashbacks, headaches, blank spells, being recognized by people the patient does not know, or being called by a different name.

Depersonalization Disorder is assessed by asking about feeling unreal, being outside one's body, looking at oneself from overhead or at a distance, dizziness, perceptual clouding, and perceived bodily changes like enlarged extremities. Ask about comorbid symptoms of depression and anxiety.

Past psychiatric history: Past psychiatric diagnoses, hospitalizations, and treatments. Dissociative symptoms can appear in schizophrenia, Somatoform Disorders, major depression, bipolar disorder, obsessive-compulsive disorder, acute or post-traumatic stress disorder, panic disorder, borderline personality disorder, and histrionic personality disorder. A history of anxiety and depressive symptoms is a predisposing factor to developing a dissociative disorder.

Substance abuse history: Substance intoxication can cause dissociative symptoms; therefore, ask specifically about alcohol, benzodiazepines, marijuana, hallucinogens, and barbiturates.

Social history: Family relationships, divorce, marital discord, exposure to domestic violence, history of physical abuse, sexual abuse or other traumatic events. Ask about legal history and possible motivations for secondary gain.

Family history: Psychiatric disorders in family members, relatives seeing a psychiatrist, or taking psychiatric medication. Dissociative identity disorder may occur more frequently among first-degree relatives.

Past medical history: Neurological disorders, head trauma, seizures, brain tumors, and migraine headaches can all cause dissociative symptoms. Hypothyroidism and hypoglycemia can also cause depersonalization symptoms.

Medications: Medications, including over-the-counter and alternative treatments. Depersonalization may be a side effect of several medications, including beta-blockers and anticholinergics.

Mental Status Exam

General appearance: Patients may appear in distress, clearly disturbed by the amnesia or dissociative experience, or they may be unaware of symptoms. General appearance can vary according to personality in dissociative identity disorder.
Speech: Normal rate, rhythm, and volume.
Mood: "Scared."
Affect: Anxious, dysphoric.
Thought process: Linear and goal-directed.
Thought content: No delusional content elicited. Reality testing is characteristically intact.
Perceptual: The patient typically denies auditory or visual hallucinations, but may experience dissociative symptoms, such as derealization or depersonalization. Doubling may also occur in which patients feel as though they are observing themselves from a distance.
Suicidality: Suicidal ideation is possible during times of extreme stress.
Homicidality: Denies.
Sensorium/cognition: Alert and oriented, cognition is intact. Perform a full mini-mental state exam in patients with amnesia to rule out dementia.
Impulse control: Impaired during times of extreme stress.
Judgment: Fair. Patients typically understand how behavior affects others and voluntarily seek treatment.
Insight: Limited. Patients are unaware of the relation of the symptoms to past experiences or their significance as a psychological defense mechanism.
Reliability: Good. The patient is able to describe symptoms in detail unless amnesia prevents awareness.

Laboratory data: Complete blood count, chemistry, thyroid function tests, toxicology screen and blood alcohol level, and pregnancy test.

Diagnostic testing: Electroencephalography, computed tomography, and the Dissociative Experience Scale.

Diagnosis: Axis I: Dissociative amnesia**,** dissociative fugue**,** dissociative identity disorder**,** and depersonalization disorder**.**

Differential Diagnosis

Psychiatric: Delirium, dementia, schizophrenia, major depression, bipolar disorder, obsessive-compulsive disorder, posttraumatic stress disorder, acute stress disorder, somatization disorder, Conversion Disorder, substance intoxication or

withdrawal (alcohol, barbiturates, benzodiazepines, hallucinogens, marijuana), borderline personality disorder, and histrionic personality disorder.

Medical: Hypoglycemia, hypothyroidism, carbon monoxide poisoning, botulism, hyperventilation, fatigue, fever, sensory deprivation, and medication toxicity or side effect.

Neurological: Epilepsy, head trauma, brain tumor, migraine, encephalitis, and cerebrovascular disease.

Dissociative Disorders - Discussion

I. Epidemiology. Amnesia is the most common dissociative disorder. Dissociative disorders may occur in people of any age, but are more common in young women. Risk factors include a history of trauma, such as physical abuse, sexual abuse, emotional neglect, loss of a loved one, or witnessing a death. Dissociative fugue is extremely rare, but may occur in the context of psychosocial stressors, such as divorce or financial hardship.

II. Etiology. Dissociative phenomena are considered immature psychological defense mechanisms, which protect against experiencing the pain of trauma.

III. Clinical evaluation

- **A. The history of present illness** should focus on the nature of the symptoms and try to differentiate from among the dissociative disorders.
- **B. Dissociative amnesia** typically has an abrupt onset, and the patient is aware of the memory loss. Memory loss may be *localized* for a specific period of time, *selective* for certain events, or *generalized* across a lifetime.
- **C. In dissociative fugue**, patients wander away from home for hours to days and may assume another identity. Unlike dissociative amnesia, patients in a fugue state do not recognize their memory loss or identity confusion.
- **D. Dissociative identity disorder** was previously called multiple personality disorder. It is characterized by two or more distinct identities that alternate in controlling the patient's behavior. The patient may refer to himself as "we," and typically the patient does not recall time spent in alternate self-states. Patients with dissociative identity disorder may not recognize the existence of different identities within themselves.
- **E. In depersonalization disorder**, patients have a sense of detachment from themselves, and may describe feeling unreal, or in a dream-like state. Patients may also describe observing themselves from a distance. Depersonalization symptoms are experienced as abnormal and distressful, although a non-pathological variant that is not distressful to the patient also exists.

IV. Treatment

- **A. Inpatient hospitalization** is rarely necessary unless symptoms of comorbid psychiatric disorders are present and require admission. It is possible that alternate identities in dissociative identity disorder may exhibit impulsivity and suicidal or homicidal behavior, which mandates hospitalization.
- **B.** Benzodiazepines, barbiturates, hypnosis, and relaxation techniques may all be useful to facilitate recall in amnesia.
- **C.** Psychotherapy may help patients to recognize the impact of past traumatic events and

address the associated pain with improved coping strategies.

References, see page 92.

Somatization - History Taking

History of present illness: Current symptoms, duration, date of onset, psychosocial stressors, and associated distress. Ask about pain, gastrointestinal distress, sexual dysfunction, and neurological symptoms. Somatization disorder is assessed by asking about pain, nausea, vomiting, bloating, diarrhea, and constipation. Decreased libido, erectile or ejaculatory dysfunction, irregular menses, and menorrhagia. Weakness, paralysis, loss of balance, sensory deficits, difficulty swallowing, blindness, double vision, and seizures.

Conversion disorder symptoms appear neurological in origin and may consist of deficits in any sensory or motor system. A fear of having a medical illness suggests hypochondriasis. Body dysmorphic disorder is assessed by asking about preoccupation with an imagined bodily defect and perceived misshapen body parts, such as hair, nose, skin, eyes, and mouth.

Past psychiatric history: Ask about past hospitalizations, diagnoses, treatments, and suicide attempts. Previous conversion symptoms, depression, anxiety, schizophrenia, and histrionic personality disorder are seen more frequently as comorbid illness in somatoform disorders.

Substance abuse history: Alcohol, cocaine, heroin, marijuana, hallucinogens, sedatives, hypnotics, anxiolytics, and analgesics. Substance abuse occurs more frequently in patients with somatization disorder and increases the risk of suicide.

Social history: Living situation, family relationships, level of education, income, history of physical or sexual abuse, and psychosocial stressors, such as loss of a loved one, marital conflict, and divorce. Conversion symptoms are more likely to occur in patients with a low level of education, low socioeconomic status, a history of abuse, and in the context of psychosocial stressors.

Family history: Substance abuse, cluster B personality disorders, and somatization disorder occur more frequently in family members of patients with somatization disorder.

Past medical history: Ask about past medical illness, hospitalizations, surgeries, and neurological problems. Dementia, brain tumors, myasthenia gravis, multiple sclerosis, systemic lupus erythematosus, seizures, acute intermittent porphyria, polymyositis, HIV, and Guillain-Barre syndrome can all cause symptoms that mimic somatization disorder and conversion disorder.

Medications: Medical, alternative, and all over-the-counter medications.

Mental Status Exam

General appearance: Calm and cooperative; the patient may not exhibit an appropriate level of concern about symptoms.
Speech: Normal rate, rhythm, and volume.
Mood: “Scared,” “upset” or “depressed.”
Affect: Dysphoric or anxious. The patient may show inappropriate (incongruent) affect when describing potentially serious symptoms.
Thought process: Linear and goal-directed, but often ruminative about symptoms.

Thought content: Illogical. Ideas of reference of people noticing the perceived defect may occur in body dysmorphic disorder. Concern about symptoms and fear of illness do not reach delusional proportions in somatoform disorders.
Perceptual: Denies hallucinations or illusions.
Suicidality: Denies active suicidal ideation, but may have a history of suicide attempts.
Homicidality: Denies.
Sensorium/cognition: Alert and oriented; intact memory and concentration, and good fund of knowledge.
Impulse control: Fair. There is no evidence of poor impulse control.
Judgment: Fair. The patient is aware of effect behavior may have on others.
Insight: Limited. The patient does not understand the psychological nature of symptoms.
Reliability: Fair. The patient describes symptoms in detail, but may exaggerate the severity.

Laboratory data: Complete blood count, chemistry, liver function tests, urinalysis. Laboratory examinations should be symptom-oriented to rule out specific differential diagnoses.

Diagnostic testing: Physical and neurological exams; magnetic resonance imaging, electroencephalography, and electrocardiogram should be done as needed on a symptom-oriented basis.

Diagnosis: Axis I: Somatization disorder, conversion disorder, hypochondriasis, body dysmorphic disorder, pain disorder.

Differential Diagnosis

Psychiatric: Major depression, panic disorder, generalized anxiety disorder, phobias, histrionic personality disorder, borderline personality disorder, and schizophrenia may all present with somatic complaints consistent with somatoform disorders.

Medical/neurological: Brain tumors, systemic lupus erythematosus, myasthenia gravis, multiple sclerosis, polymyositis, Guillain-Barre syndrome, AIDS, optic neuritis, Creutzfeldt-Jakob disease, and periodic paralysis.

Somatoform Disorders - Discussion

I. **Epidemiology.** The prevalence of somatoform disorders varies according to the specific disorder, but pain is the most common presenting complaint.
II. **Etiology.** The etiology of somatoform disorders includes Freudian theories of repressed intrapsychic conflict, misinterpreted somatosensory input, and secondary gain where patients derive specific benefit from entering the sick role. There are also recent neuroimaging studies and other data to support biological and genetic roles in the development of somatoform disorders.
III. **Clinical evaluation**
   A. **Somatoform disorders** are characterized by physical symptoms that are not intentionally produced, but have no medical cause.
   B. **Somatization disorder** is diagnosed by a history of multiple physical complaints beginning before age 30. Specific complaints must include four pain symptoms, two gastrointestinal symptoms, one sexual symptom other than pain, and one neurological symptom.
   C. **Conversion disorder** is characterized by motor and sensory symptoms that appear neurological in origin. Paralysis, blindness, and mutism are the most common conver-

sion symptoms. Pseudoseizures may also occur in conversion disorder, and they are most common in patients who already suffer from a seizure disorder.

D. The classic sign associated with conversion disorder is "la belle indifference," where patients do not appear appropriately concerned about seemingly serious symptoms.

E. Hypochondriasis patients are convinced they have a particular disease despite all evidence to the contrary. Hypochondriasis can be distinguished from other somatoform disorders because patients are preoccupied with the fear of having an *illness*, rather than concern about the *symptoms* themselves.

F. Body dysmorphic disorder is characterized by a preoccupation with an imagined or exaggerated bodily defect, such as a deformed nose. Ideas of reference, compulsive checking of the defect, and rituals to hide the defect may also develop. Patients with body dysmorphic disorder may have a long history of plastic surgery, and different body parts can be affected throughout the course of the disorder.

G. In pain disorder, symptoms can affect any part of the body and must be severe enough to cause impairment in social and occupational functioning. There may be an underlying medical condition contributing to the pain, but psychological factors must also play a significant role.

IV. Treatment

A. Inpatient hospitalization for patients with somatoform disorders may be required for stabilization if functioning is severely impaired or suicidal ideation is present. Treatment usually consists of cognitive-behavioral or insight-oriented psychotherapy.

B. Routine physical and neurological exams are helpful for reassurance and to rule out the development of an underlying medical etiology.

C. Biofeedback training and relaxation techniques may also be helpful to reduce symptoms.

D. Pharmacotherapy is useful in treating comorbid anxiety and depressive disorders. Pain disorder is sometimes treated with amitriptyline or gabapentin. Body dysmorphic disorder may respond to serotonin reuptake inhibitors.