The Psychiatric Interview and Mental Status Examination

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Psychiatric Interview

• Is the most important element in the evaluation and care of persons with mental illnesses.

• A major purpose of the initial psychiatric interview is to obtain information that will establish a criteria-based diagnosis. This process, helpful in the prediction of the course of the illness and the prognosis, leads to treatment decisions.
Conduct of the psychiatric interview

• Goals and Purpose
The psychiatrist should consider a number of important issues in preparation for conducting a psychiatric interview.

Relevant questions to establish the goals and purpose of the interview include the following:

- Is this interview being conducted for diagnostic or therapeutic purposes?
- What does the psychiatric interviewer know about the patient and the patient’s expectations for this interview?
- What does the patient know about the psychiatrist or the psychiatrist’s goals for this encounter?
- What does the patient expect to happen during and after this interview?
Conduct of the psychiatric interview

• Guidelines for the interview
The interviewer must understand many other parameters before beginning the actual interview:

- Under what circumstances is the psychiatric interview occurring?
- Who requested and who made arrangements for the psychiatric interview to take place?
- Will the results of the psychiatric interview be confidential?
- Is the patient participating voluntarily in the interview?
- How much time does the psychiatrist have to conduct the psychiatric interview?
The Interview Room

• Many psychiatrists suggest that the interviewer’s chair and the patient’s chair be of relatively equal height so that the interviewer does not tower over the patient (or vice versa).
• It is generally agreed that the patient and the psychiatrist should be seated approximately 4 to 6 feet apart.
• The psychiatrist should not be seated behind a desk.
• The psychiatrist should dress professionally and be well groomed.
• Distractions should be kept to a minimum.
Below is an example of an interview room, highlighting the good and bad features in terms of safety.

**High-security window.**
Natural daylight and fresh air can be calming for the patient.

**Unobstructed viewing window**
to allow for observation by other staff.
The interview room should be located close to staff areas.

**Easily accessible, functioning alarm systems,**
i.e. one in the room and one mobile alarm with staff.

**All potential weapons must be removed,** i.e. sharp/glass objects, anything containing boiling water, etc. The room should be a designated interview room, rather than having a dual function such as an office or storage area, which could compromise safety features.

**It may be advisable to also have a nurse present in the assessment.**

**Clear, unobstructed exits.**
 Doors should not be lockable from the inside and should allow for easy access from the outside in the event of an emergency.
Process of the psychiatric interview

• The first-and perhaps most important- task is to establish **rapport** with the patient being interviewed.

• In the clinical setting, rapport can be defined as the harmonious responsiveness of the physician to the patient and the patient to the physician.

• Developing an effective working alliance with the patient is generally accomplished by communicating respect and empathy to the patient.
Process of the psychiatric interview

• Communicating respect includes:
  Appropriate introduction of one's self to the patient.
  Respectfully asking the patient how he or she wishes to be addressed during the interview.

• Respectful and empathic communication involves:
  Making appropriate eye contact
  Observing nonverbal cues
  Limiting interruptions.
Process of the psychiatric interview

- **Empathy** is understanding what the patient is thinking and feeling and it occurs when the psychiatrist is able to put himself or herself in the patient’s place while at the same time maintaining objectivity.
Process of the psychiatric interview

• Empathic communications show the patient that the psychiatrist is trying to listen and observe from the patient's perspective.

• The psychiatrist is attempting to understand the patient's experience from the patient's point of reference.

• This often requires that the psychiatrist acknowledge when his or her own thoughts, feelings, perceptions, or experiences differ from the patient’s. The psychiatrist, then, should deliberately choose to focus on the patient's experiences and needs rather than on his or her own experiences or needs.
Early in the interview, the psychiatric interviewer should ask questions that create opportunities for expanding his or her emotional connection with the patient.

For example, an empathic response by the psychiatric interviewer to a patient who shares that his 70-year-old grandmother has just died from complications of heart disease might be "Were you and your grandmother close?" Examples of less empathic responses by the psychiatric interviewer might be "My grandmother is about to celebrate her 90th birthday next month" or "Does anyone else in your family have heart disease?"
Process of the psychiatric interview

• The more empathic response focuses on the patient’s emotional experience of his grandmother's death.

• The first less empathic response focuses on the interviewer more than the patient.

• The second less empathic response focuses away from the patient's emotional experience and more toward data gathering.

• If the psychiatrist has very limited time within which to complete the interview, and/or if this exchange were to occur toward the end of the interview time, the third response might be acceptable and even necessary.
Process of the psychiatric interview

• Open questions where possible, especially at the beginning, e.g., “how is your appetite?”.
• Closed questions are useful if time is short, e.g., “is your appetite good?”
• Avoid leading questions e.g., “You have a poor appetite, don’t you?”.
Tasks for the therapist conducting a psychiatric interview

1. Establish goals.
2. Establish rapport.
3. Develop a collaborative doctor-patient relationship.
5. Communicate in a language that the patient understands, and avoid psychiatric jargon.
6. Monitor the emotional intensity of the interview and adjust as necessary.
7. Gather pertinent psychiatric history data.
Tasks for the therapist conducting a psychiatric interview

8. Perform a mental status examination.
10. Assess patient safety.
11. Develop a plan for possible emergencies.
12. Review previous records and other available data.
13. Interview others as appropriate.
15. Manage time.
Outline of the interview write-up

1. Identifying information
2. Chief complaint
3. History of present illness
4. Past psychiatric history
5. Past medical history
6. Family history
7. Developmental and social history
8. Mental status examination
9. Diagnoses
10. Assessment and formulation
11. Treatment plan
Components of the Psychiatric Write-Up

1. Identifying information
   
   Can either be limited to gender and age or include a lengthy list of potentially important demographics. For most purposes, it is useful to target variables that are pertinent to the particular interview.

   Typically includes the patient’s name, age, sex, marital status and occupation.
Components of the Psychiatric Write-Up

2. Chief Complaint

Is intended to be the patient's primary psychiatric concern and is generally written as a quotation. It is, therefore, not the spouse's biggest complaint, or the prior therapist’s biggest concern, or the interviewer’s assessment of what should be the chief complaint.

An opening, nondirective question might be

"Tell me about what brought you here today."

Examples include, “I am depressed” or “I have a lot of anxiety.”
Components of the Psychiatric Write-Up

3. History of Present Illness (HPI)

Is the interviewer's integrated narrative of the patient’s current psychiatric illness. The development of an accurate and effective HPI can be deceptively difficult.

Once the actual illness has been clarified, the HPI should feature a narrative that includes important precipitants as well as the onset, duration, intensity, and debility of symptoms.

Commonly associated comorbidities and symptoms should be specifically included or excluded.
Components of the Psychiatric Write-Up

4. Past Psychiatric History

Should focus on data that can guide current and future evaluations. Ideally, historical diagnoses should be accompanied by a list of pertinent symptoms and potential contributors, such as substance abuse. In discussing hospitalizations, the clinician would ideally elicit the name of the institution, the reason for admission, the discharge diagnosis, and the treatment and its efficacy. Mention of a medication or psychotherapy should be followed by the interviewer's best estimate of duration, intensity, adverse effects, level of adherence, and effect. Collateral information is important because patient recall can be fuzzy.
Components of the Psychiatric Write-Up

5. Past Medical History

Is potentially critical because psychiatric and nonpsychiatric medical conditions are frequently comorbid.

In addition to eliciting a list of prescribed medications, the clinician should inquire about over-the-counter, complementary, and alternative medications, as well as activities that may potentially be therapeutic, such as exercise, yoga, and meditation.
Components of the Psychiatric Write-Up

6. Family History

Refers to pertinent disorders found in biological relatives.

Schizophrenia in a brother definitely should be recorded in this section.

Diabetes in a first-degree relative may also be pertinent, especially given the link between metabolic syndrome and many psychiatric medications, and between diabetes and depression.
Components of the Psychiatric Write-Up

7. Social History

– Does the patient have a stable place of residence that is safe and affordable?
– Has anything about the patient’s living situation changed recently?
– Are any changes expected in the near future?
– Does the patient have a reliable source of income?
– Is the patient working?
Components of the Psychiatric Write-Up

7. Social History

– Does the patient have an adequate support system, including family, friends, neighbors, and so on?
– Is the patient's support system reliable and available in times of need?
– Is the patient married, single, divorced, separated?
– Does the patient have children?
– Does the patient have family nearby and available to help?
– What is the nature of the patient's relationship with his or her family—that is, is the family supportive and helpful or intrusive and difficult?
Components of the Psychiatric Write-Up

8. Personal History
   – Mother’s pregnancy, birth.
   – Early development, illness.
   – Childhood separation, emotional problems.
   – Relationships with family members.
   – School- academic performance and peer relationships.
   – Qualifications. Further education.
   – Occupations, work performance.
   – Sexual relationships, marriage, children.
   – History of abuse (physical, sexual, emotional) in childhood or adulthood.
Components of the Psychiatric Write-Up

9. Premorbid personality History
   – Ask patient how others see them or would describe them.
   – Prevailing mood; how they get on with people; deal with stress.
   – Leisure activities and hobbies.
Components of the Psychiatric Write-Up

10. Forensic History

– Record all offences- convicted or not.
– Violence/Anger, sexual offences.
Mental Status Examination (MSE)
Mental status examination

• The mental status examination (MSE) is the psychiatric equivalent of the physical examination in the rest of medicine.

• The MSE explores all the areas of mental functioning and denotes evidence of signs and symptoms of mental illnesses.

• Data are gathered for the mental status examination throughout the interview from the initial moments of the interaction, including what the patient is wearing and their general presentation.

• Most of the information does not require direct questioning.
Mental status examination

- The MSE gives the clinician a snapshot of the patient’s mental status at the time of the interview and is useful for subsequent visits to compare and monitor changes over time.
Mental status examination

• General Appearance And Behaviour
• Speech
• Mood and affect
• Thought Form
• Thought Content
• Perception
• Cognition
• Insight
• Judgment
General Appearance and Behaviour

• A description of the person’s general appearance is typically the first element of a mental status examination.
• It consists predominantly of the assessor’s impressions and observations of what the person looks like and how they behave throughout the assessment and can provide the clinician with cues by which to further investigate other areas of the mental status.
General Appearance and Behaviour

- **Age:**
  Does the patient appear to be his or her stated age, younger or older?
  Commonly used descriptions include “appears stated age” or “appears older/younger than stated age”.

- **Apparent health**
- **Level of hygiene**
- **Mode of dress**
- **Any physical abnormalities** or striking features should also be recorded, such as tattoos, needle marks, scars, skin lesions or discoloration.
- **Facial expressions**
  May convey happy, sad, anxious, fearful or perplexed states of mind.
Behaviour

- **Eye contact**
  - *Suspicious* persons may avoid eye contact.
  - *Depressed* patients often look downwards.
  - *Hallucinating* patients may look in unexpected directions in response to their own internally produced visual or auditory stimuli.

- **Movement**
- **Motor activity**
  - May be described as normal, slowed, or agitated.

- **Expressive gestures**
  - Pacing, hand wringing, fist clenching or shaking, grimacing, repetitive touching of the face and so forth.

- **Cooperativeness**
  - Adjectives such as friendly, trusting, preoccupied, suspicious, arrogant, sarcastic, guarded, vigilant, threatening, hostile, impatient etc are good descriptions to summarize the overall cooperativeness of the patient.
Speech

- **Volume**
- **Amount**
  - The amount of speech produced ranges from sparse to talkative.
  - Mutism is the absence of speech and can result from psychiatric or neurologic causes.

- **Rate**
  - Is it normal, slowed or rapid (pressured).

- **Spontaneity**
  - Is the degree to which the patient initiates and engages in conversation.
  - Depressed patients commonly demonstrate decreased spontaneity of speech.
  - Paranoid or suspicious patients may be hesitant to initiate conversation.
Mood and affect

- Mood and affect are terms used to describe emotional or feeling states.
- Mood is a person’s internal and sustained emotional state.
- "How have you been feeling lately."
Mood and affect

• Affect is the external and dynamic manifestation of a person's internal emotional state.

• Described in terms of:
  - Range (full, restricted, blunted, flat)
  - Stability (stable, labile)
  - Appropriateness And Congruity
Affect

• Range

A full range of affect means that a variety of normal emotions are noted during the interview; that is, the patient is capable of showing appropriate sadness, happiness, anger, laughter, seriousness, and so on, depending on the context.

Flat Affect: A state in which there is no emotional expression. The patient with flat affect also has minimal variability of facial expression, shows no gesticulations, and speaks in a monotone voice.
Affect

• Stability
  - The rate at which affect changes is the mobility of affect.
  - A normal capacity to change is described as mobile affect, while excessively rapid and unprovoked changes indicate a labile affect.
  - A brain damaged (e.g., pseudobulbar palsy) or delirious patient's affect can be labile from minute to minute. It is not unusual for these patients abruptly to grimace, cry, or sob, only to return to a calm expression a few seconds later.
Affect

• Appropriateness And Congruity

Affect is normally appropriate to, or congruent with, the environment, topic of conversation, or situation.
Thought Form

• The way in which thoughts flow, are connected to one another, and are expressed to the listener.

• Was the conversation logical and goal directed, or was it confusing and vague?

• Was it easy to gather information, or did the examiner have to work hard at asking questions to elicit information?
Thought Form

• *Circumstantiality*
  - Means "talking around" a topic. Such speech is digressive and overly detailed, but eventually returns to the original topic or makes the relevant point (if it fails to accomplish this, the speech should be described as circumstantial and tangential).
  - Can occur in: - Epilepsy
    - Learning disability
    - Obsessional personality traits.
Thought Form

• *Tangentiality*
  The topic of conversation had strayed down another path or direction (tangent) without eventually returning to the original topic.
Thought Form

• **Flight of Ideas**

  - Each sentence is more or less logically connected to the preceding one, but the topic repeatedly changes before elaboration of each thought can occur. This is seen most often in manic patients, typically in conjunction with pressured speech.

  - 3 components have to be there:
    – pressure of speech
    – shifting topics
    – apparent association (can be followed)
Thought Form

• **Loosening Of Associations**
  - Loss of the normal structure of thinking
    - Muddled and illogical conversation that cannot be clarified by further enquiry.
  - Several forms:
    - Knight’s move / derailment:
      » transition from one topic to another with no logical connection between the two.
    - Word salad:
      » severe form of derailment affecting the grammatical structure of speech.
      » words are no longer meaningfully connected to one another.
Thought Form

• Perseveration
  - Words, phrases or ideas persist beyond the point at which it is relevant, e.g. same answer to each question (stimulus).
  - Differs from verbal stereotypy
  *Verbal stereotypy (verbigeration): words, sounds or phrase repeated in a senseless way (no stimulus).
Thought Form

• **Echolalia**

  Patients with echolalia repeat statements and questions made by the examiner, sometimes more than once. For example, when the examiner asks "What is today's date?" the patient replies "What is today's date?"
Thought Process

• Neologism: use of novel words or of existing words in a novel fashion.

• Thought block: sudden arrest of the train of thought, leaving a “blank”.

• Clang associations: speech based on sound such as rhyming and punning (i.e., My car is red. I’ve been in bed. It hurts my head.).
Thought Content

- Suicidal ideation/homicidal ideation
- Delusions
- Overvalued Ideas
- Preoccupations
- Obsessions
- Phobias
Thought Content

- Suicidal ideation/homicidal ideation
  
  Ask if the patient feels like harming him/herself or others.

  Identify if the plan is well formulated.

  Ask if the patient has an intent (i.e., if released right now, would he go and kill himself or herself or harm others?)

  Ask if the patient has means to kill himself (firearms in the house/ multiple prescription bottles).
Thought Content

• Delusions

False, unshakeable belief that is out of keeping with the patient’s social and cultural background.
Themes of Delusion

– Persecutory (paranoid):
  • Others/organizations trying to inflict harm on him.
  • Believe that he is being conspired against or persecuted in some way.
  • Have you had trouble getting along with people?
  • Have you felt that people are against you?
  • Has anyone been trying to harm you in any way?
  • Do you think people have been conspiring or plotting against you? Who?
Themes of Delusion

– Delusion of Jealousy:
  • common in men.
  • May develop gradually.
  • delusion of unfaithfulness of spouse (infidelity).
  • spying, checking on spouse, examine for sexual secretions, may progress to violence against the spouse and even to murder.
  • The patient believes that his or her spouse or partner is having an affair with someone.
  • Random bits of information are constructed as “evidence”.
  • Morbid jealousy makes a major contribution to the frequency of wife battering, and is one of the most commonest motivations for homicide.
Themes of Delusion

– Delusion of Love “erotomania”
  • De Clerambault’s Syndrome
    – being loved by a man who is inaccessible, high status, never spoken before, unable to reveal his love for her
Themes of Delusion

• Grandiose (expansive):
  ■ beliefs of exaggerated self-importance
  ■ e.g. wealth, special powers, beauty

• Religious delusions
  - The patient is preoccupied with false beliefs of a religious nature.
  - Have you had any unusual religious experiences?
Themes of Delusion

– Delusions of Reference:

• Idea that objects/events/people have a personal significance for patient e.g. TV programmes, news.

• The patient believes that insignificant remarks, statements, or events have some special meaning for him or her.
Themes of Delusion

– Delusion of Guilt and Worthlessness:
  • e.g. minor past faults will be exposed, being sinful, deserves to be punished.

– Nihilistic Delusion
  • belief about non-existence of some person / thing + pessimistic ideas e.g. career is gone
  • Cotard’s Syndrome: failures of bodily functions e.g. bowels are rotting etc.

– Hypochondriacal Delusions
  • belief of ill health despite contrary medical evidence.
  • usually of a particular theme & may have relative/friend suffering the supposed illness
Disorders of Thought Possession

– **Thought Insertion:**
  
  • delusion that some thoughts have been implanted by outside agency.

– **Thought Withdrawal:**
  
  • delusion that thoughts have taken out of his mind (may accompany/explain thought block).

– **Thought Broadcasting:**
  
  • delusion that his unspoken thoughts are known to other people.
Thought Content

• Overvalued ideas
  -Ideas held with a lot of emotion (highly charged) but with some degree of ambivalence and doubts about the belief.
Thought Content

• Pre-occupations

   Ideas which come to mind, again and again and may prevent the patient from performing his day to day activities.
Thought Content

• Obsessions:
  – recurrent persistent thoughts, impulses or images that enter the mind despite efforts to exclude them.
  – subjective sense of struggle to resist them.
  – recognized as his own (not implanted).
  – regarded as untrue and senseless.
Thought Content

• Phobias:
  - Persistent, irrational fears.
Perception

- Perception means the process of becoming aware of what is presented through the sense organs i.e. the understanding of a sensory stimulus.

- Alterations in Perception:
  - Illusions
  - Hallucinations
  - Depersonalization
  - Derealization
Perception

• Illusions
  – misperceptions of external (objective) stimuli
  – conditions more likely to occur:
    • reduced level of sensory stimulation (e.g. at dusk)
    • reduced level of consciousness (e.g. delirious pts.)
    • when attention is not focussed on the sensory modality (e.g. in darkness)
    • when there is a strong affective state (e.g. stressed up / angry)
• Hallucinations
  – sensory perception without an objective stimulus but with a similar quality to a true percept.
  – experienced as originating in the outside world and not in the mind (like imagery)
  – can be of all sensory modalities:
    • visual / auditory / tactile
    • gustatory / vestibular / olfactory
Description of hallucinations

• According to complexity
  – Elementary
  – complex

• According to sensory modality

• According to special features
  – auditory: 2nd or 3rd person
Auditory hallucinations

– Elementary / complex

– Voices
  • single/multiple
  • male/female
  • known/unknown person
  • person
    – 1st person: “thought echo” - hearing own thoughts spoken aloud (Gedankenlautwerden, echo de la pensee)
    – 2nd person: calling patient by ‘you’
    – 3rd person: calling patient by ‘he’ or ‘she’
Auditory hallucinations

- Voices
  - commanding / running commentary / arguing with each other
  - timing:
    - day / night / all the time
    - circumstances when it occurs
    - continuous / intermittent / frequency
  - theme:
    - friendly, derogatory
- patient’s response to the voices
Visual Hallucinations

– elementary (e.g. flashes of light)
– complex
  • semi-formed: with some structure
  • fully-formed: e.g. human figures, trees
– black and white / coloured
– static / mobile
– stable form / changing design
– size (e.g. Lilliputian)
– commonly associated with organicity
Other hallucinations

– Olfactory and gustatory hallucinations
  • often experienced together
  • often unpleasant in nature (e.g. rotten fish, bitter)
  • common in temporal lobe epilepsy

– Tactile
  • Superficial( haptic): touched, pricked e.g. insect crawling under the skin (e.g. formication in cocaine abuse)
  • deep sensation: e.g. viscera being pulled out, sexual stimulation, electric shock
- Autoscopy hallucination
  - seeing own body projected into objective space (can happen in depression)
  - "negative autoscopy" also can occur!
• Extracampine hallucinations:
  – perceiving a sensation from beyond the limits of the sense organ
  – e.g. visions from outside visual field, hearing voices from far away

• Reflex hallucinations:
  – stimulus in one sensory modality causing a hallucination in a different sensory modality
  – e.g. music causing visual hallucination (LSD abuse)
Hypnogogic and hypnopompic hallucinations

—occurs at the point of falling to or waking from sleep

—usually brief and elementary
Other Perceptual Disturbances

- Depersonalization: a feeling that his body parts are abnormal, unreal
  - e.g. “my brain becomes big until it fills the room”
- Derealization: a feeling that the external environment is abnormal, unreal
  - e.g. people are two dimensional card board figures
- both can occur in tiredness, temporal lobe epilepsy, depression, etc.
Cognition

• The ability to use intellect, thought, and ideas to comprehend inner and outer realities. A combination of cortical functions is involved in cognition, which includes language, memory, attention, perception, judgment, reasoning, and recognition.
Cognition

- Orientation
- Memory (immediate recall, short-term memory, long-term memory)
- Attention And Concentration
- Abstraction
Orientation

- Orientation to person, place, and time is a basic cognitive function.
- Essentially, this means that patients should know who they are, where they are, and what the time and date are.
Immediate memory

• Is essentially an assessment of attention
• Is most often tested by asking patients to repeat the names of three unrelated objects (e.g., apple, table, penny).
Short-term memory

• **Recent or short-term memory** is typically tested by asking the patient to recall after a few minutes the three objects repeated.

• If the patient was unable to repeat the objects in the first place, the inability to recall after 3-5 minutes does not necessarily indicate the loss of short term memory but could instead reflect inattention or amotivation.
Long-term memory

• Long-term memory is generally assessed during the course of interview through the patient’s ability to accurately recall events in recent months and throughout the course of a lifetime.
Attention And Concentration

• Attention is the ability to sustain interest in a stimulus, whereas concentration involves the ability to maintain mental effort.
• Counting backward by 7s (serial 7s) requires that the patient retain interest in the task, recall the last number, and then continue to the next number. The task also requires competence at math.
• Spelling world backward is another test.
• For other patients, it is preferable to use a test that is less dependent on education, such as reciting the months backward.
Abstract thinking

• Is the capacity to conceptualize meanings of words beyond the most literal (concrete) interpretation. This includes the ability to analyze information according to themes, to generalize according to categories, to appreciate double meanings, to make comparisons, to hypothesize, and to reason using deductive and inductive thinking.
Abstract thinking

• Assessment of the ability to identify similarities and interpret proverbs is a common approach to testing abstraction.

• "In what way are an apple and an orange alike?" The correct answer is that they are both fruit; this is an abstract answer. An answer that they both are round is concrete; that they can both be eaten is somewhat less concrete.
Abstract thinking

• Proverb interpretation is another way to test abstraction.
• "Don't count your chickens before they hatch“
• Abstract interpretation is "Don't be prematurely expecting something that might not happen.”
• Possible concrete interpretation is "You won't know how many chicks will be born by counting the eggs."
Insight

• Insight, in the psychiatric evaluation, refers to the patient’s understanding of how he or she is feeling, presenting, and functioning as well as the potential causes of his or her psychiatric presentation.
Insight

• Assessment of insight focuses on whether patients recognize that they are ill, comprehend that their problems are deviations from normal, understand that their behaviour may affect others, and appreciate that treatment may be helpful in alleviating symptoms.

• This information is elicited through direct questions, for example: "Are you ill?" "What has brought you to see me?" "Have you had thoughts that other people view as abnormal, or are not normal for you?" "Do you realize that your family thinks you have been depressed?"
Insight

- Knowledge of the illness and presenting problem
- Knowledge about medication
- Amenable to treatment Person
- Likelihood of compliance

• The patient may have no insight, partial insight, or full insight.
Judgment

• Judgment refers to the person’s capacity to make good decisions and act on them.
• The level of judgment may or may not correlate to the level of insight.
• A patient may have no insight into his or her illness but have good judgment.
• “What would you do if you found a stamped envelope on the sidewalk?”
Judgment

- The important issues in assessing judgment include whether a patient is doing things that are dangerous or going to get him or her into trouble and whether the patient is able to effectively participate in his or her own care.
Key clinical points

• Nonverbal communication and observation are crucial.
• Without a strong fund of knowledge, the interviewer will get lost.
• Information is useful only when interpreted.
• Not all information is relevant.
• The interview should be adapted to fit the patient and the situation.
• The history of present illness is a creation of the interviewer.
• The history of present illness is longitudinal.
• The mental status examination is cross-sectional.
• It is difficult to balance the many mandates of the psychiatric interview, but the task is made easier through the active cultivation of such interpersonal characteristics as curiosity and warmth.
THE END!