Chapter 1

Introduction

Marsal Sanches and Jair C. Soares

This book aims at providing the reader with an introduction to psychiatry and to the study of mental disorders. While still addressing basic theoretical concepts of importance for the understanding of psychiatry as a specific field of knowledge, its main focus is not an extensive discussion or a comprehensive review of research findings. Instead, whenever possible, the different topics are addressed from a practical point of view, allowing the reader not only to expand their base knowledge but, most importantly, to obtain a good picture of how patients experiencing these conditions usually present themselves in clinical contexts. Moreover, the treatment of mental disorders is addressed in an objective, straightforward way, based on the respective authors' own clinical experience in the management of a high number of patients, in different settings.

The chapters are sorted into two distinct portions. The first half of the book (Chapters 2–15) comprises general topics of interest for psychiatrist and mental health workers. Themes such as the psychiatric interview, psychopathology and the mental status exam, diagnostic and classification in psychiatry, and introduction to psychosocial aspects of psychiatric care, along with the biological basis of mental illnesses, are provided. Specific chapters focusing on transcultural and ethico-legal aspects of psychiatry, as well as the practice of psychiatry in special populations (children and adolescents, geriatric patients, and women in reproductive age), are also included. Two chapters address biological treatments in psychiatry (psychopharmacology and neurostimulation techniques). The last two chapters of this section focus on suicide and psychomotor agitation utilizing a syndromic approach, given the importance of these conditions in psychiatric practice and their transdiagnostic nature.

In contrast, Chapters 16–32 address specific conditions or groups of disorders most commonly seen in psychiatric practice. Most chapters in this portion of the book are organized in the same way, with different sections contemplating general considerations, pathophysiological aspects, clinical presentation, and therapeutic aspects of each disorder or groups of disorders. Nonetheless, in the description of clinical features and diagnostic considerations, the contributors were given full discretion to utilize a more systematic, criteria-based approach (according to contemporary international classifications) or to use a more generic clinical framework, based on their own preference and the approach usually adopted by them in their respective daily practices. Despite the popularity and importance of systematic classifications in psychiatry, the goal of this book is not to provide a comprehensive list of diagnostic categories and criteria for every single condition hereby discussed, and the reader primarily interested in detailed information on such criteria should consult specific diagnostic manuals or books primarily focused on systematic classifications of mental illnesses [1–3].

Last, despite all the efforts made by the authors in providing accurate and up-to-date information in the present book, the field of psychiatry is constantly evolving. The authors, editors, and publisher make no warranties that the information included in this book is totally free from error. The data included in this book with regards to the diagnosis and management of patients with mental disorders (including medication risks, benefits, and side effects) are not meant to be comprehensive, and providers should consider consulting additional resources (including information provided by manufacturers, in the case of medications) before making treatment decisions. Ultimately, providers carry the responsibility for treatment decisions made in the management of patients under their care, and the authors, editors, and publisher disclaim any responsibility for the continued currency of this information and disclaim all liability for any and all damages (including direct or consequential damages) that might result from the use of information contained in this book.

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Chapter 2

The Psychiatric Interview

Dean J. Atkinson and Amanda Helminiak

2.1 Introduction

The psychiatric interview is of paramount importance in the field of psychiatry, allowing the clinician to connect with the patient and to collect sufficient information to guide treatment. Once concluded, the interviewer should be able to describe the patient's complaints, appearance, and situation in a manner that informs diagnostic and therapeutic decisions [1]. Some of the complexities faced include conducting a mental status exam while trying to establish therapeutic rapport, soothing the patient's suffering, interviewing for diagnostic criteria, and arranging a treatment plan. It is often assumed that the skills for this crucial assessment will be "learned on the job," but this approach is fraught with possibilities for developing bad habits and failures at rapport-building. Instead, by dedicating attention to this topic, trainees may be empowered to meet these challenges as confident and effective interviewers. While some variables may prove unpredictable at times, the interviewer may bring order to the encounter through the deliberate application of learned skills. Continuous self-reflection is essential for improvement and is important for both trainees and seasoned veterans alike. This chapter will discuss the mindful preparation, execution, and assessment of effective interviews.

2.2 Before the Interview

In preparing for the interview, it is important to consider the environment in which it will take place. This includes the physical location (i.e., office environment vs. emergency room), the presence of distractors, and general ambience. There will be substantial differences between a patient encounter in a quiet, planned, office visit compared with the loud, unpredictable, and chaotic nature of a high-acuity psychiatric inpatient unit. The interviewer should strive to minimize any challenges inherent to their individual setting and create a calm environment for the patient. Whenever possible, interviews should provide as much privacy as possible while maintaining safety. It is also worth noting that the patient's emotional state can have significant implications for the quality of the assessment. It is quite difficult to obtain a valid history from an acutely agitated and aggressive patient or from a profoundly depressed patient with little speech output. Other patients may be guarded due to paranoia, anxiety, or skepticism toward health care workers, which can also impair data collection. In some cases, these factors may be modifiable within a reasonable time frame, which would make a brief postponement acceptable. In other circumstances, the interviewer may not have this luxury and will have to proceed as able. In the hospital setting, it is also best to avoid interruptions to sleep, meals, and recreational activities so as to minimize frustration and distraction.

Before engaging any patient in a clinical interview, some effort should be made to collect any pertinent and available data relevant to the situation. This information will highlight important topics and inform the interviewer about potential pitfalls. The amount of information might be very limited, such as that obtained during a walk-in emergency department encounter, or it could be extensive, such as when detailed notes have been provided by a transferring facility. Past records can be particularly illuminating, especially if current symptoms bear some similarity to prior presentations. A word of caution: Though this chart review can be quite helpful, it may be incorrect for a variety of reasons. Similarly, it is also not uncommon for collateral information to be inaccurate, even if well intended. One must therefore maintain an air of skepticism and flexibility, avoiding a rigid path of exploration.

After reviewing the information, it is worthwhile to identify which interview topics are best to prioritize; for example, assessing suicide risk factors in a patient with depression will be of greater importance than their educational history. This is not to say that a full initial history is unimportant, but rather to point out that some triage may be necessary, due to time limitations or other constraints. The bottom line is to review the available information, get a basic impression of what the interview will entail, and formulate a strategy for proceeding accurately and in a timely manner.

The components of a typical psychiatric interview include the Chief Complaint, History of Present Illness, Review of Systems, Past Psychiatric History, Past Medical History, Family History, Social History, and the Mental Status Examination. In the following section, a variety of techniques for structuring and navigating through the psychiatric interview will be discussed in more detail.

2.3 During the Interview

To emphasize the unique nature of the psychiatric interview, consider the similarity to the services of a locksmith. Clients seek the services of a locksmith to help them gain access to something important that they cannot unlock on their own. Slight tension or pressure can help focus and gently guide patients toward progress, but too much pressure will be disruptive and counterproductive. Psychiatrists must attend closely to each step in the interview, assessing the response to individual lines of questioning and adapting their approach to find the next best step, focusing on using the right tool for the job.

To unlock a complex patient history, the first focus should be on building good rapport with the patient. Patients who like their clinicians feel more comfortable sharing intimate details of their lives and are more likely to follow treatment recommendations. To achieve a strong therapeutic alliance is a challenging and nuanced art form and requires thoughtful intention. Renowned psychologist Carl Rogers advocated for a client-centered approach to this task, emphasizing the principles of Genuineness, Unconditional Positive Regard, and Accurate Empathy [2]. **Genuineness** entails the interviewer being authentic and honest, even if this means not representing a model of perfection. At times this may inadvertently lead to conflict or may compromise the perceived authority inherent in the clinician's role; however, relatability and accessibility are predominantly more beneficial. With **Unconditional Positive Regard**, the interviewer strives to be accepting of the client for who they are and to refrain from judgment. Finally, **Accurate Empathy** involves the ability to understand emotions from the

patient's perspective while maintaining appropriate professional distance. In addition, this principle requires the ability to communicate this understanding effectively to the patient.

From the field of motivational interviewing, the use of simple and complex reflections may be of great utility to this end [3]. **Simple Reflections** comprise the patient's own words or very similar verbiage and involve the clinician merely repeating them to demonstrate listening. **Complex Reflections**, by contrast, are those in which the psychiatrist has added their own interpretation to more fully imply their understanding of what the patient has expressed. For example, if a patient says, "I have been feeling so angry at my spouse," the clinician may demonstrate a simple reflection by stating, "You've been really upset." Alternatively, the clinician may utilize a complex reflection, bringing in their perceived alternate viewpoint. For example, they could reply, "You have been feeling unappreciated lately." Here, the interviewer is using an educated guess, potentially unlocking the true underlying sentiment at hand, which may not yet be in the patient's conscious awareness.

In engaging with the patient, body language is also critical to keep in mind; for example, arm-crossing and leaning away from the patient may lead to disengagement, while open body language and leaning forward in an interested way can allow the patient to feel more at ease. Conversely, the interviewer may attend to the patient's body language as an indicator of their engagement.

Much like the approach a locksmith must take to an unyielding door, the interviewer should be strategic and flexible, employing a variety of tools to achieve their goal. To tackle the interview with a rote checklist would be metaphorically similar to gaining entrance to a locked room by way of a sledgehammer. This is not guaranteed to be effective and may cause irreparable harm. In reality, the ideal interview is one that does not feel much like an interview. With sufficient practice, the experience should feel more like a conversation, but one that is subtly targeted and focused without seeming rigid or overtly structured [1]. Questions are adapted from the context of the interview and follow the patient's narrative while providing opportunities to redirect and ask for additional details. While the locksmith has a variety of picks at their disposal, one toolbox available to the interviewer comes in the form of so-called **Gates**, as described by internationally acclaimed psychiatrist Shawn Christopher Shea [4]. Gates are devices to transition between topics or areas of exploration during the encounter. In other words, when used effectively, they allow an interview to feel more conversational. Though not an exhaustive list, three of the most powerful examples are the Spontaneous Gate, the Referred Gate, and the Natural Gate.

A **Spontaneous Gate** occurs when the patient changes topic and the interviewer does not redirect. If the topic change is beneficial, then this is an easy win; if this happens too often, however, it will lead to wandering. The most important thing to learn is how to recognize when the patient is changing topics and to decide how best to respond. Here is an example of a Spontaneous Gate:

Clinician: "Is this the first time you've seen a mental health professional?"

Patient: "Oh no, I've been seeing a psychiatrist off and on since I was a teenager. The last one told me I had bipolar disorder and put me on a bunch of different meds. My mom used to take meds for bipolar too."

Clinician: "Tell me a bit more about that."

In the above example, the Spontaneous Gate occurred when the patient stopped discussing their own psychiatric history and switched to family history instead, a change that was supported by the clinician. If the clinician felt the switch was premature, this could have been redirected with a short statement such as, "Before we move on to that, could you tell me which medications you've tried in the past?" If not redirected, the interviewer will likely have to come back to this topic later to obtain the remaining unknown information.

A **Referred Gate** occurs when the clinician utilizes previous content from the interview as a way to change the topic. This is fairly flexible and can be used at nearly any time, provided the interviewer has a good working memory of the conversation that has transpired. In the prior example, let's assume that the interviewer had redirected the patient away from the family history section so that they could elicit a complete past psychiatric history. If they now wish to change the topic to family history, they might say something like this:

Patient: "That's about all I remember about my past treatment."

Clinician: "You mentioned earlier that your mother had also been treated for bipolar disorder, what about other family members?"

Patient: "Actually yes – my brother . . . and my mom's sister too."

The interviewer above has now smoothly changed subjects by referencing a bit of information the patient has already disclosed. With this technique in mind, it is good to be cognizant of what the patient is saying at all times, tucking away opportunities to be used in future parts of the interview.

A **Natural Gate** occurs when the interview uses a patient's recent statement as a springboard, asking a transition question to switch the topic. These require some creativity, but once mastered, they are extraordinarily powerful.

Patient: "I've been seeing a psychiatrist off and on since I was a teenager. The last one told me I had bipolar disorder and put me on a bunch of different meds."

Clinician: "Does anyone else in the family have bipolar disorder?"

In this example, the interviewer is choosing to initiate a transition from the patient's past psychiatric history into family history. With practice, this technique has an enormous potential for flexibility.

By utilizing the above transitions, an interviewer can learn to smoothly guide the progression of the encounter in a conversational manner while retaining control over the direction and content discussed.

When engaging with a patient, it is important for an interviewer to monitor not only the content of their speech but also their manner of speaking [5]. The tone of a statement can dramatically affect the way it is perceived, even when the content is identical. Consider the difference in emphasis between "Oh, that makes sense" (said with a thoughtful facial expression) and "Oh, THAT makes sense" (said with a slight smirk). The first would likely be perceived as supportive, while the latter could be interpreted as sarcastic. While the tone of voice is certainly important, facial expression and overall demeanor can have a significant impact as well. **Affect Matching** is a term used to describe the efforts made on the part of the interviewer to slightly mirror the patient [3]. If they are speaking with a low volume and tone of voice, such as is often seen in depression, the interviewer would be wise to

lower their own volume and tone to more closely approximate that of the patient. This should be evaluated on a case-by-case basis and is not always appropriate, but generally speaking, patients will be more comfortable sharing information with someone whose manner does not contrast sharply with their own.

It is also important to avoid jargon and to speak at the level of your patient, something that can occasionally be achieved by incorporating their own language into your own [5, 6]. Medical terminology often enters into the general public's lexicon and cannot always be trusted to convey an accurate message (e.g., bipolar, OCD).

Special attention should also be given to phrasing in a nonjudgmental manner, if the interviewer wishes to obtain accurate data. For example, consider the differences between asking "How far did you **go** in school?" and "How far did you **get** in school?" The first is a fairly benign historical question that entails a choice on behalf of the patient. The second can be perceived as condescending, almost as if to say, "How far did you get before you couldn't get any farther?" Interviewers may find patients more willing to share about sensitive topics like substance use by asking about "experimentation" with "recreational drugs" rather than asking about "abuse" of "illegal drugs."

In addition to avoiding judgmental statements, it is important to be flexible when screening for psychiatric symptomatology. A common error among trainees and seasoned clinicians alike is to lapse into routine forms of screening questions. Too often, for instance, the only screen for auditory hallucinations in every patient seems to be: "Are you hearing things that other people don't hear?" or "Are you hearing any voices?" There are numerous problems with this. The first is that these questions will feel contrived when used in a rote manner and not adapted to the patient's own unique experience. The second is that many patients will perceive the question incorrectly. Patients experiencing hallucinations rarely characterize them as "hallucinations," since this would mean they are not real, when to the patient they are experienced as very real indeed. Patients who have substantial history speaking with mental health professionals know all too well that the term "voices" really means "hallucinations." The third issue is that these questions are too specific. Although auditory hallucinations in the form of a voice are fairly common, this represents only one type of auditory hallucination that could be experienced. Clinicians should continuously monitor their phrasing, searching for areas to optimize in a patient-centered manner. Any demonstrable pattern that does not incorporate the individual patient's clinical picture and history should be looked upon with great scrutiny and preferably transformed into a more nuanced screening question whenever possible. Any phrasing that could be misconstrued as judgmental or is otherwise off-putting should be adjusted accordingly.

Another nonverbal area that warrants attention is the application of body language. Clinicians should attend to their own facial expressions, body position, and posture. Some facial reactivity is expected when patients divulge details to communicate empathy, though too much can be counterproductive. For example, it would be inappropriate to have no reaction to a patient's recounting of a substantial past trauma, but if the interviewer's reaction communicates discomfort or shock, this may cause a patient to stop sharing additional information. Concerning the rest of the body, an effort should be made to meet the patient on their level, preferably both parties sitting and turned at an angle. An interviewer who stands over the patient may be perceived as looking down on them, in congruence with their physical state. It is also helpful to maintain an open stance, avoiding the crossing of arms (even if the room is cold). For paranoid patients, great care

must be taken to keep hands visible at all times rather than clasped behind the back or stuffed into pockets. An engaged interviewer will find themselves leaning in toward the patient in a listening stance rather than sitting far back in their chair in an unconscious attempt to escape from the conversation. Some notetaking is appropriate, as it demonstrates attentiveness, though if patients appear uncomfortable, this should be minimized.

2.4 After the Interview

In order to continue developing improved interview skills over time, it is necessary to be intentional about self-reflection following patient encounters. Tracking the length of time spent on the interview, any lapses in information gathering, and the quality of therapeutic alliance achieved are important. It is also reasonable to seek the guidance of more seasoned practitioners in determining areas for optimization. Some licensing programs require periodic graded patient encounters to be performed, during which the observers rate the interviewer on the success of data collection, the ability to develop a rapport with the patient, and subsequent presentation skills.

2.5 Conclusion

With dedication and practice, both locksmiths and mental health clinicians alike can solve even the most intricate puzzles using the right tools. The clinician must be appropriately empathic and nonjudgmental, even paying attention to their own body language so as to convey active listening and alliance with the patient. In their discussion with the patient, a skilled interviewer should masterfully employ techniques such as Gates to acquire important information with finesse. Finally, continual growth should be sought over time through self-assessment, or through external assessment options when available. It is by this process that clinicians may develop into excellent interviewers who are more readily able to help their patients. Although important, historically there has been a lack of directed educational initiatives to improve interviewing skills [7]; emphasizing these with an intentional curriculum may serve future mental health clinicians.

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Chapter 3

Psychopathology and the Mental Status Examination

Marsal Sanches

3.1 Introduction

Based on the current standards established for the practice of psychiatry, a formal psychiatric evaluation must include a detailed, itemized description of the mental status exam (MSE). Despite considerable variations with regards to its structure and the terminology utilized in its description, the MSE carries considerable weight from a clinical, decision-making, and even legal perspective.

The MSE, in its current format, was conceived as the psychiatric equivalent of the physical examination. For purposes of documentation, it is considered, by most practitioners, the "objective" portion of the psychiatric assessment, in contrast with history data (obtained from the patient and from other sources), which comprise the "subjective" part of the examination. Nonetheless, except for some of its portions, which require specific questions for purposes of clarification, most of the MSE is performed concomitantly to the process of history taking and is based on the observations of the psychiatrist during the interview.

This process of formulation of the MSE is closely related to the concept of psychopathology itself. Psychopathology, in a more basic sense, is the study of the experiences reported by the patient that deviate from normality, acquiring a pathological meaning [1]. Obviously, defining what is "normal" in psychiatry is not an easy task, as a certain behavior or experience can be considered normal or pathological depending on different factors, including the patient's cultural context, the degree of suffering experienced by the patient as a result of the experience or behavior, and the functional impact of the behavior in question, among others. Because of that, the MSE is based on the so-called phenomenological approach [2]. This means that, during the interview, the psychiatrist critically analyzes the experiences reported by the patient, as well as the behaviors displayed during the assessment, and reaches conclusions regarding their nature, by trying to "place themselves in the patient's shoes" and comparing those experiences with their own and with similar experiences reported by other individuals the interviewer has previously interacted with. In addition, the interviewer should take into account other elements, such as the context of the interview and the sociocultural environment in which the patient is immersed. A conclusion regarding the nature of the elements reported or displayed by the patient is then eventually reached [3]. The different psychopathological elements identified through this process will then become a key element for the formulation of the patient's psychiatric diagnosis (Figure 3.1).

The present chapter provides a succinct description of the MSE and of the main psychopathological concepts of interest.

Table 3.1 The Mental Status Examination

1. General Appearance and Presentation
2. Psychomotricity
3. Speech
4. Thought Process
5. Thought Content
6. Mood
7. Affect
8. Sensoperception
9. Insight and Judgement
10. Cognition

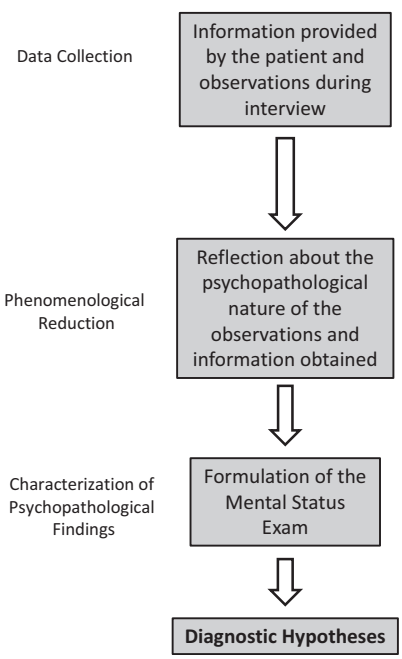

Figure 3.1 Obtaining the diagnosis – a flow chart.

3.2 Structure of the Mental Status Exam

There are different ways to organize the mental status exam. The structure presented below (also repeated in Table 3.1) is among the most popular ones and tries to avoid the overlap of elements for which a more objective description is feasible (e.g., general appearance) with others, which are based on inferences regarding the patient's inner state and specific mental functions (e.g., thought process).