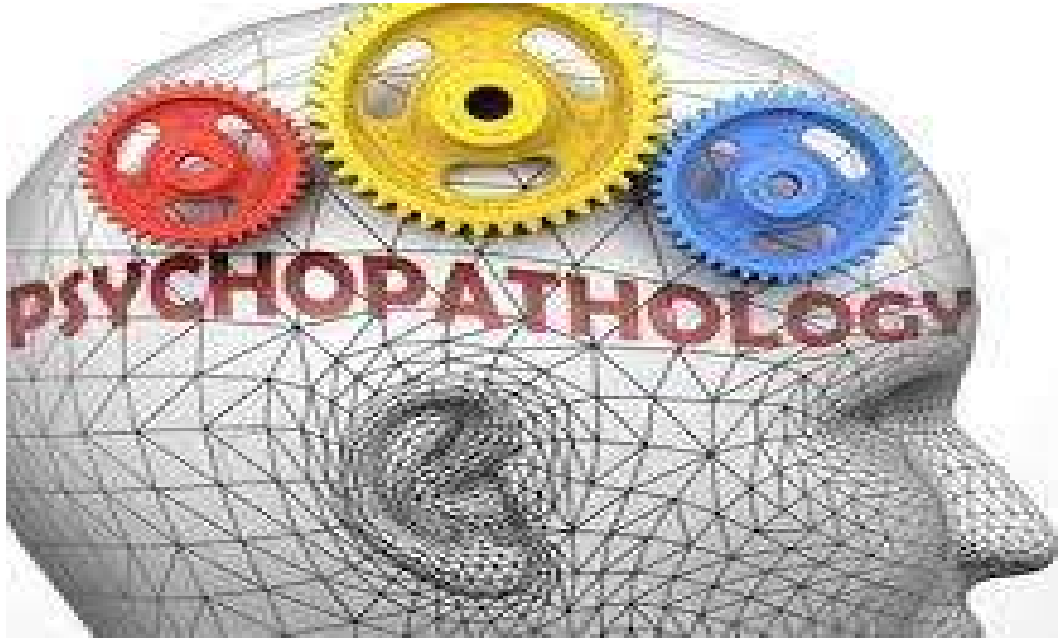
MEDICAL UNIVERSITY OF LODZ

General Psychopathology & Mental Status Examination



Department of Affective and Psychotic Disorders

Diagnosis

- Decisive activity and process, of utmost importance in medicine
- Etymologically: to distinguish, to discern
- Diagnosis vs person: A diagnosis is a conceptualisation of a clinical condition as it appears at the time of seeking treatment. It is not the same thing as a summary of who the person is. Is not necessarily stable over time.
- **"Diagnosis is really understanding what goes on in the mind and the body of the person who presents for care"**

Diagnosis – basic principles

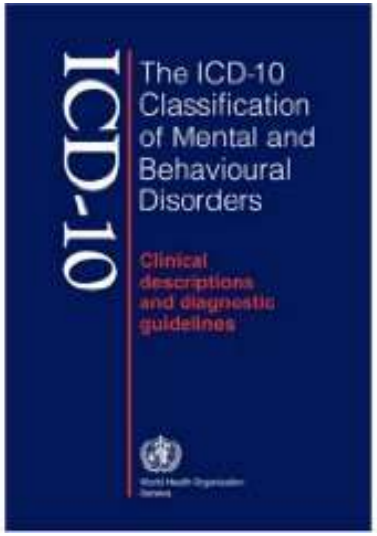
- Diagnosis must arise from responsible assesment and evaluation
- Diagnostic terms must be used in accordance with accepted nosology
- Diagnosis must be scientifically defensible
- Labelling – occurs when the term is used to describe or summarize the person – i.e., „a schizophrenic" or „an alcoholic"

Diagnostic work-up in psychiatry

- Mental Status Examination
  - clinical interview
  - behavioral assessment
- Physical examination (general + neurological)
- Laboratory investigations
- Neuroimaging
- Psychophysiological assessment (EEG, sleep tests)
- Psychological testing
  - Projective tests
  - Personality tests
  - Intelligence tests
- Neuropsychological testing

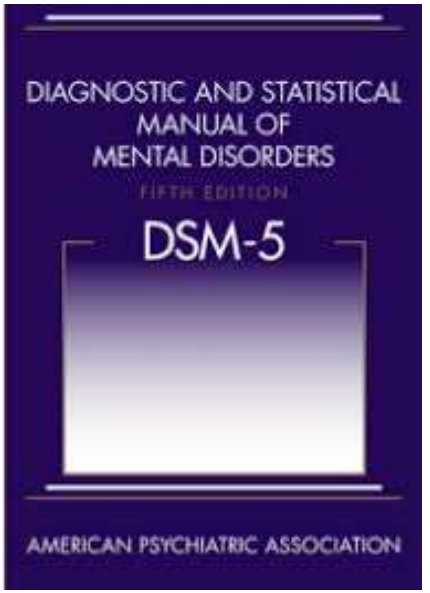
Final diagnosis – classification systems

ICD-10 (international)



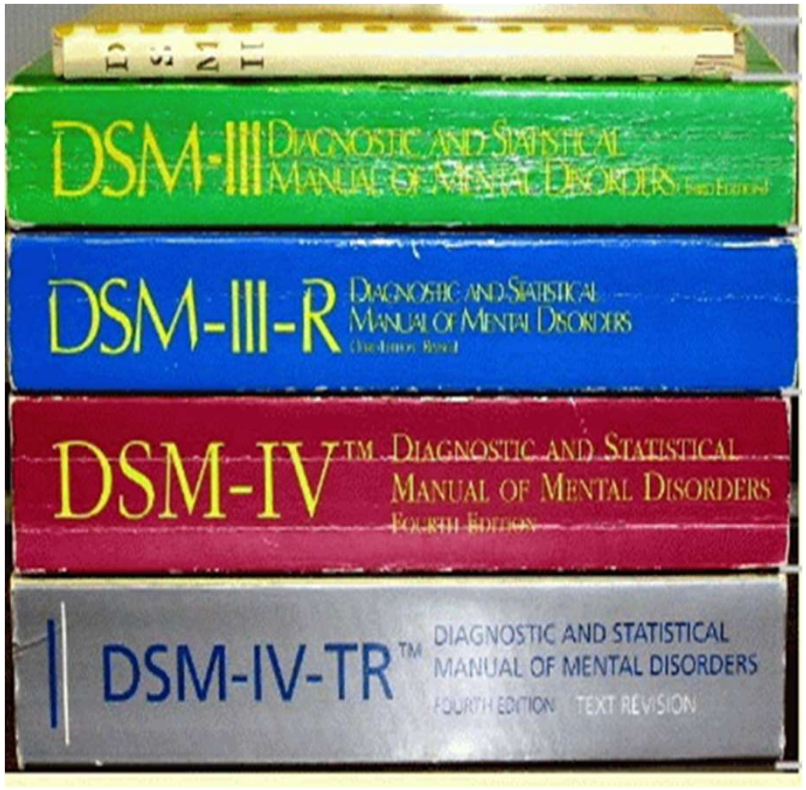
International Statistical Classification of Diseases and Related Health Problems(ICD-10) – World Health Organization

DSM-5 (American)



The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) – The American Psychiatric Association

Final diagnosis – classification systems



- The DSM-5 is the first DSM to use an Arabic numeral instead of a Roman numeral in its title.
- In most respects, the DSM-5 is not greatly modified from the DSM-IV-TR; however, some significant differences exist between them.

DSM-5 mental disorder concept

- 'A clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g. a painful symptom) or disability (i.e. impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.

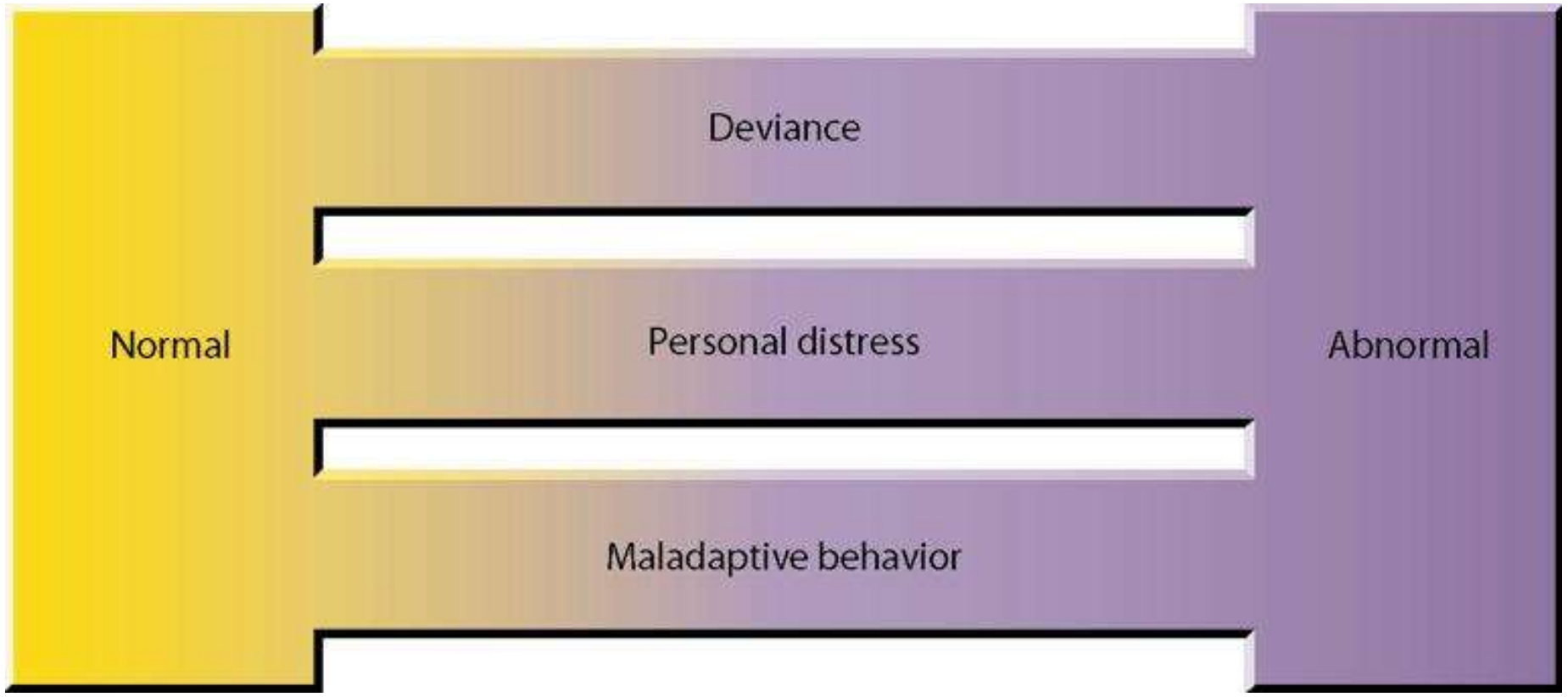
- Not merely an expectable and culturally sanctioned response to a particular event, e.g. the death of a loved one.

- 'Whatever its original cause, it must currently be considered a manifestation of a behavioural, psychological, or biological dysfunction in the individual. Neither deviant behavior (e.g. political, religious or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom or a dysfunction in the individual.'

Diagnostic criteria

- Defined cluster of symptoms
- Present for a given period of time
- Significant impairment or decline form a previous level of functioning
- Exclusion criteria (e.g., general medical condition, psychoactive substances)

Abnormal Behavior



Normality and abnormality as a continuum. There isn't a sharp boundary between normal and abnormal behavior. Behavior is normal or abnormal in degree, depending on the extent to which one's behavior is deviant, personally distressing, or maladaptive.

Line between

- Mental health professionals **determine (judge)** where on the continuum behavior lies
- Which criteria to use?
  - Bizarreness of Behavior
  - Persistence of Behavior
  - Social Deviance
  - Subjective Distress
  - Psychological Handicap
  - Effect on Functioning

History and Mental Status Examination

- The physical exam for the psychiatrist.
- Describe the mental state and behavior of the person.
- Includes both objective observations of the clinician and subjective descriptions given by the patient.
- Using terms like “normal” or “within normal limits” to summarize aspects of the exam is inadequate and inappropriate.
- To properly assess the MSE, information about the patient's history is needed, including education, cultural and social factors.
- It is important to ascertain what is normal for the patient. (For example, some people always speak fast!)

MSE - why do we do it?

- The purpose of the exam is to give a "snapshot" of the patient as he presented during the interview.
- The MSE provides information for diagnosis and assessment of disorder and response to treatment.
- If another provider sees your patient, it allows them to determine if the patient's status has changed without previously seeing the patient.

Mental Status Examination

- Evaluation of mental functioning at a point in time
- Examiner interprets the meaning of the patient's communication, verbal and non-verbal
- Rapport: The foundation of the assessment
- Examiner's Observational Skills: essential

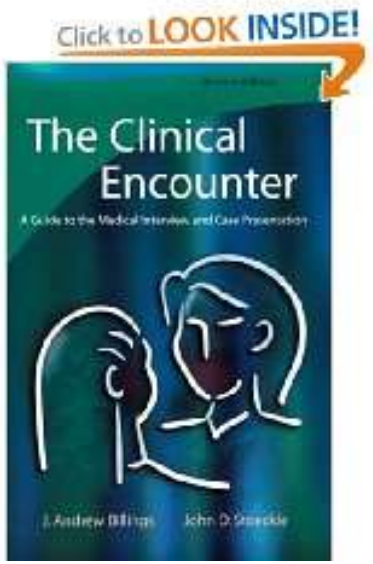
Establishing rapport

- Introduce yourself
- Explain the purpose and approx how long it will take
- Privacy
- Basic Human Comforts
- Calming and Respectful Demeanor
- Start with open questions
- Never hurry a patient – try to be empathic and listen
- You might need an informant (ask patients permission)

Mental Status Examination

- Ask open ended questions
- Allow the patient to explain things in his/her own words
- Encourage the patient to elaborate and explain
- Avoid interrupting the patient
- Guide the interview as necessary
- Avoid asking "Why?" questions
- Listen and observe for clues from the patient

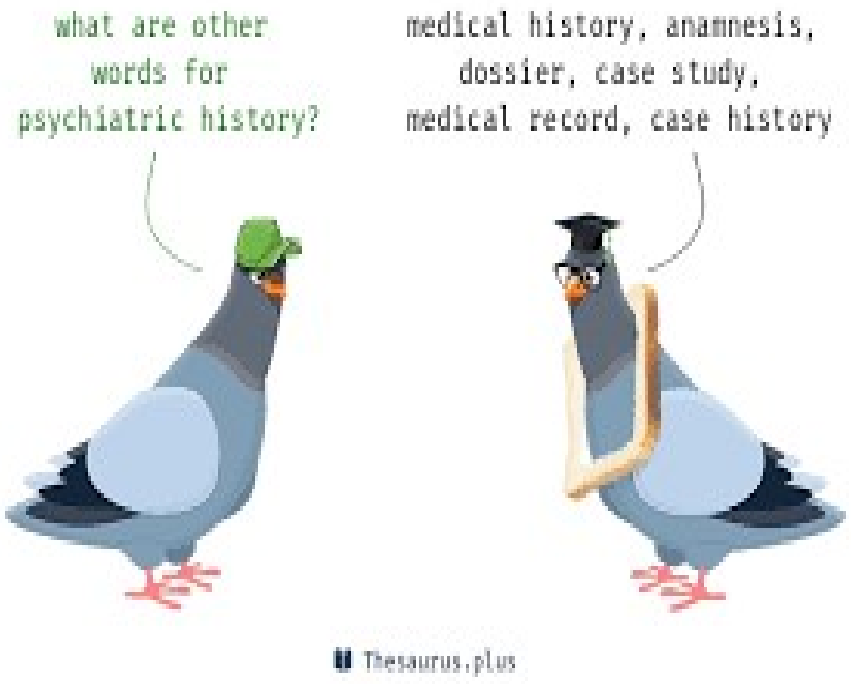
The Clinical Interview



- Structured interviewing: using validated instruments, questions can be posed in an organized and valid manner to obtain a defensible diagnosis
- Semi-structured interviewing: using either a template of basic questions or a blend of instruments plus open-ended interviewing
- Unstructured interviewing: the most common form

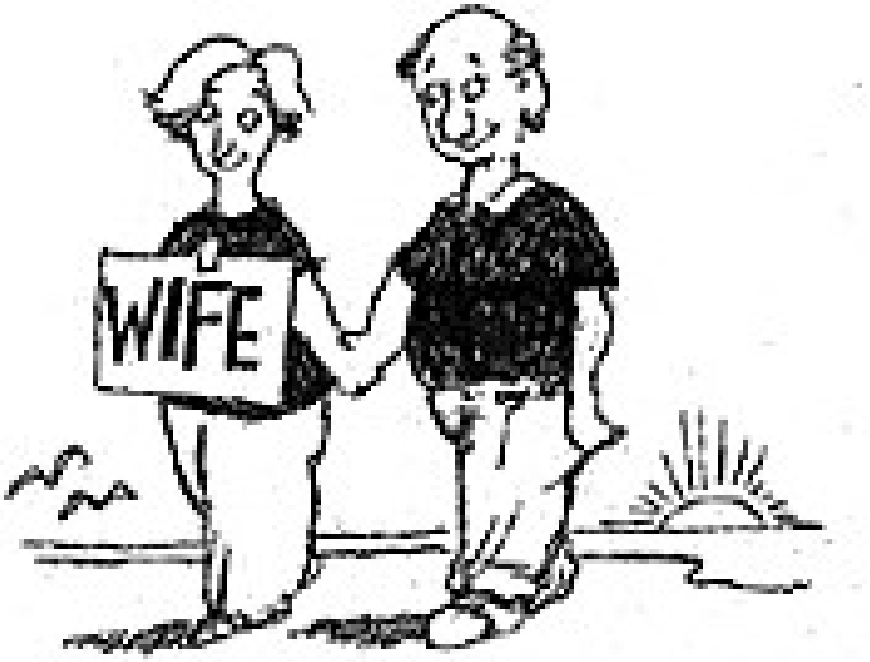
The Psychiatric History

- Basic Information
- Chief complaint
- History of Present Illness (HPI)
- Psychiatric History
- Medical History
- Medications
- Allergies
- Family History
- Social History
- Review of Systems



1)Basic Information (Sociodemographic Details)

- Name
- Age
- Gender
- DOB
- Address
- Occupation
- Marital status



2) Chief Complaint (Establish - WHY NOW?)

- You must be able to describe the presenting problem
- Presenting complaints should always be in the patient's own words

Reason for referral:

Referred by..

What are the main problems?

Which of these are the worst?

How has that affected you?

Any precipitating factors?

When did you last feel well?

- Listing specific symptoms and complaints which would justify diagnosis

3)History of Present Illness (HPI)

- This information is **probably the most useful part of the history** in terms of **making a psychiatric diagnosis**.
- It should contain a **comprehensive, chronological picture** of the circumstances leading up to the encounter with the physician.
- It is important to include details such as when symptoms first appeared, in what order, and at what level of severity, as this information is critical in making the correct diagnosis.
- Relationships between psychological stressors and the appearance of psychiatric and/or physical symptoms should be carefully outlined.

3)History of Present Illness (HPI)

- Both pertinent **positives** (the patient's complaints of auditory hallucinations) and **negatives** (the patient reports no history of trauma) should be included in the HPI.
- In addition, details of the history, such as the use of drugs or alcohol, which are normally listed in the social history, should be put in the HPI if they are thought to make a significant contribution to the presenting symptoms.

4) Psychiatric History

- Previous episodes
- Other psychiatric disorders in remission
- Past psychiatric hospitalizations
- Pharmacotherapy (including medication trials)
- History of suicide attempts
- History of self-harm (e.g., cutting, burning oneself)

5) Medical History

Any medical illnesses should be listed in this category.

Ask specifically about:

- head trauma
- seizures
- neurologic illnesses
- tumors
- HIV
- pregnancy status

6) Medications

- What medications?
- Level of prescription?
- Who prescribed medications?
- For what are the medications prescribed?

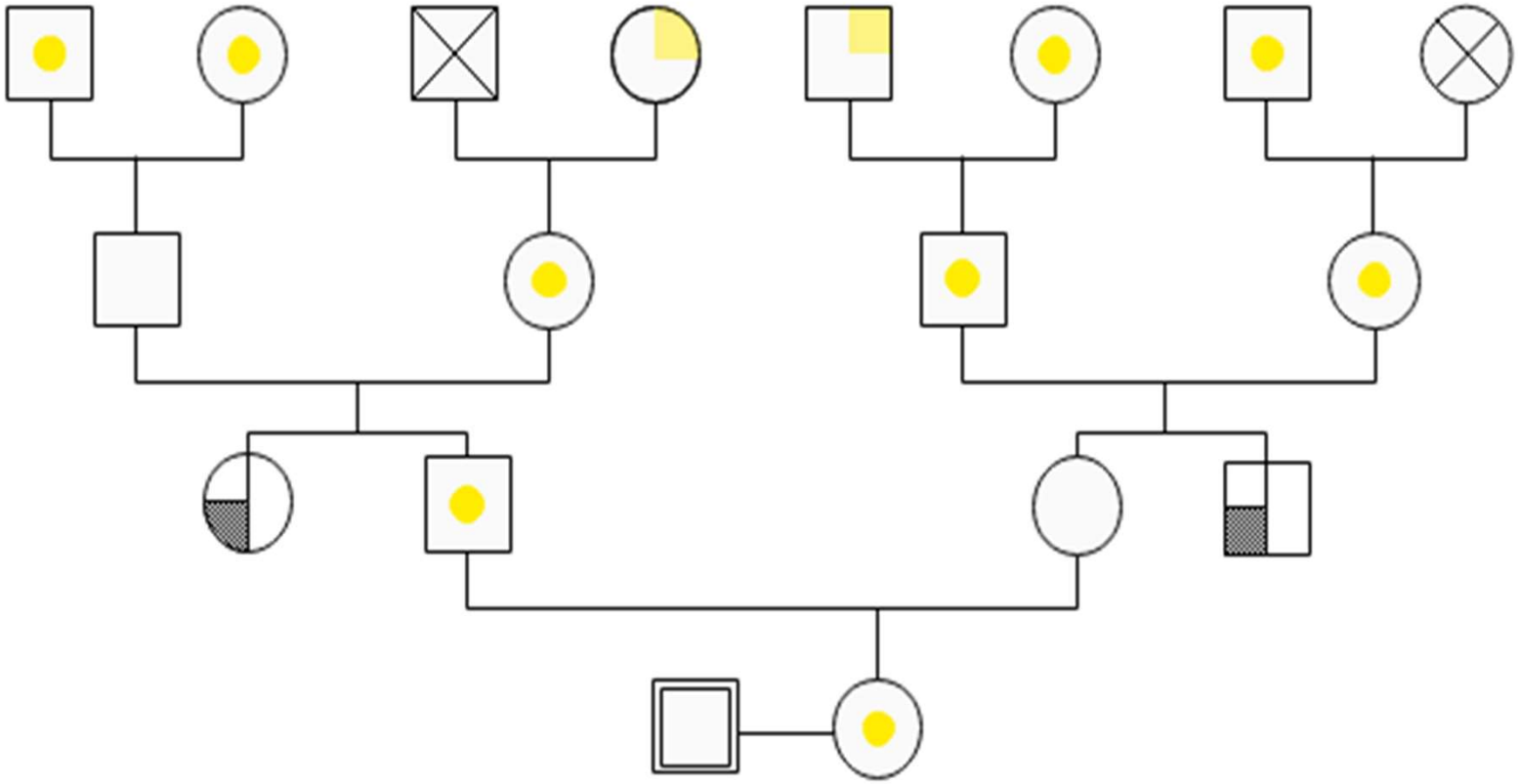
7) Allergies

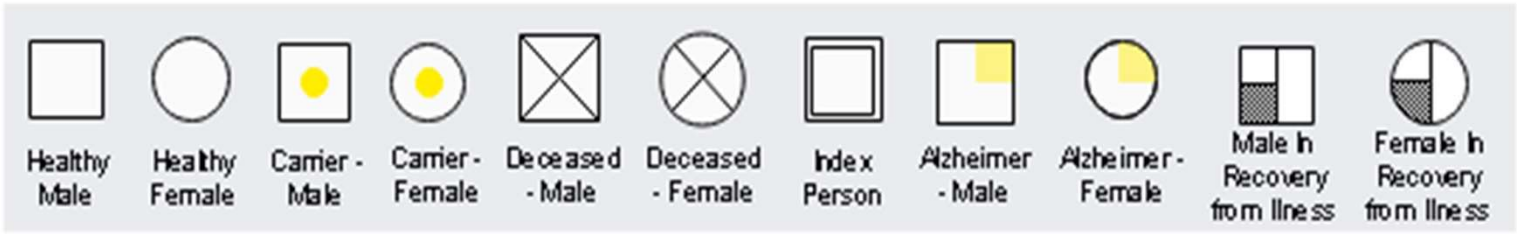
- A list of agents causing allergic reactions, including medications and environmental agents (dust, henna, etc), should be obtained.
- For each, it is important to describe what reaction actually occurred, such as a skin rash or difficulty breathing.
- Clarify if it was a true allergy or an adverse drug event (e.g. many patients who have a dystonic reaction to a medication consider it as an allergy, although it is actually a side effect of the medication).

8) Family history

- Are your parents still living? Are they well?
- Do you mind me asking how they died?
- What did your parents do?
- Do you have any brothers or sisters? Are you close to them?
- As far as you know, has anyone in your family ever had problems with their mental health?
- **Do a genogram of the family (if applicable)**
- **Identify psychosocial stressors within the family structure**
- **Mental health and/or substance abuse history with in the family and if successfully treated**

Alzheimer Medical Genogram Template





9) Social History

Infancy and early childhood

- Where were you born?
- Where did you grow up?
- As far as you know, was your mother's pregnancy and delivery normal?
- If not, were there any problems around the time of your birth?
- Did you have any serious illnesses as a young child?
- Were you walking and talking at the correct times?

9) Social History

Adolescence and education

- Which school/s did you go to?
- Did you enjoy school?
- Any lasting memories of school?
- Did you have many friends at school? Still in contact?
- When did you finish school ? Qualifications?
- Were you ever in trouble at school? ever expelled or suspended? Bullied?

9) Social History

Present social circumstances

- Education history
- Religion (religious affiliation and beliefs)
- Social history, including the nature of friendships and interests
- Relationships and marriage
  - Do you have any children? How old are they?
  - Who lives at home with you now?
  - Do you have any worries about debt or money in general?
  - Do you have friends or family who live nearby?

9) Social History

Vocational history

- Level of current employment and commitment to current job
- Relevant past employment history: length of tenure on past jobs, job hopping, relationships with work peers
- Level of satisfaction with current employment

Current living situation

- Place of residence
- Who they live with

Substance history

Forensic history

10) Review of Systems

- A systematic review should be performed with emphasis on common side effects of medications and common symptoms that might be associated with the chief complaint.
- For example, patients taking typical antipsychotic agents (such as haloperidol) might be asked about dry mouth, dry eyes, constipation, and urinary retention, which are common side effects of this medication.
- Patients with presumed panic disorder might be questioned about cardiac symptoms such as palpitations and chest pain or neurologic symptoms such as numbness and tingling, which are typical in the clinical picture of this disorder.

Resume...

- Clinical history – the single most effective tool in establishing a diagnosis
- Developing good rapport – key to effective interviewing and thorough data gathering
- Important clues:
  - the content – what the patient says and does not say
  - the manner in which it is expressed – body language, topic shifting, etc.
- Further information from the patient's family, physical examination, laboratory tests, diagnostic tools, psychological examination

Resume...

- The clinician must put together the pieces of a puzzle in order to find the single best diagnosis for the patient

MSE Components

- General Appearance
- Attitude
- Speech
- Mood
- Affect
- Perception
- Thought Process
- Thought Content
- Sensorium and cognition
- Insight/Judgment

General Appearance

Physical appearance:

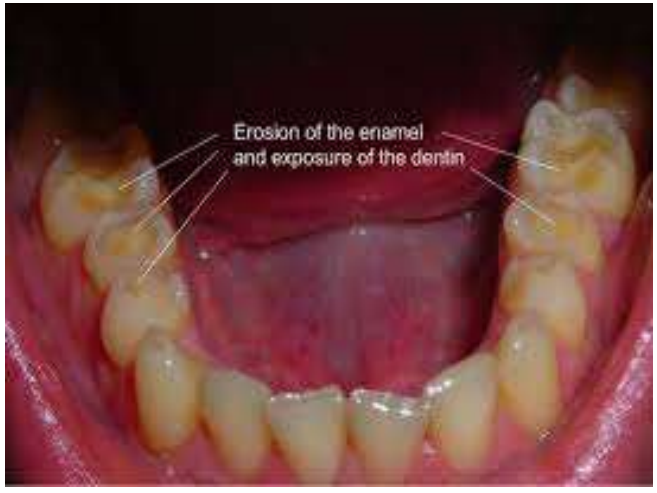
- Gender
- Age (looks older/younger than stated age)
- Type of clothing (frumpy, haggard, odd, casual, formal, skimpy)
- Hygiene (including smelling of alcohol, urine, feces)
- Posture
- Grooming
- Physical abnormalities
- Tattoos
- Body piercings

- Eye contact (fixed, avoidant, fleeting, "good," glaring, darting)

General Appearance

Take specific notice of the following, which may be clues for possible diagnoses:

- Pupil size: drug intoxication/withdrawal.
- Bruises in hidden areas: ↑ suspicion for abuse
- Needle marks/tracks: drug use
- Eroding of tooth enamel: eating disorders (from vomiting).
- Superficial cuts on arms: self-harm



General appearance

Behavior & motor activity

- psychomotor retarded
- minimal to no spontaneous movement
- fidgety, tremulous, restless
- on edge, agitated
- tics, mannerisms, tremors, convulsions
- bizarre posturing

Attitude

Stance of the patient to the interviewer

- Distant, detached
- Needy, clingy
- Sarcastic, annoyed
- Seductive, flirtatious
- Obsequious, fawning
- Cooperative, engaged
- Dismissive, indignant
- Suspicious and defensive
- Open and warm
- Hostile, evasive, guarded

Speech

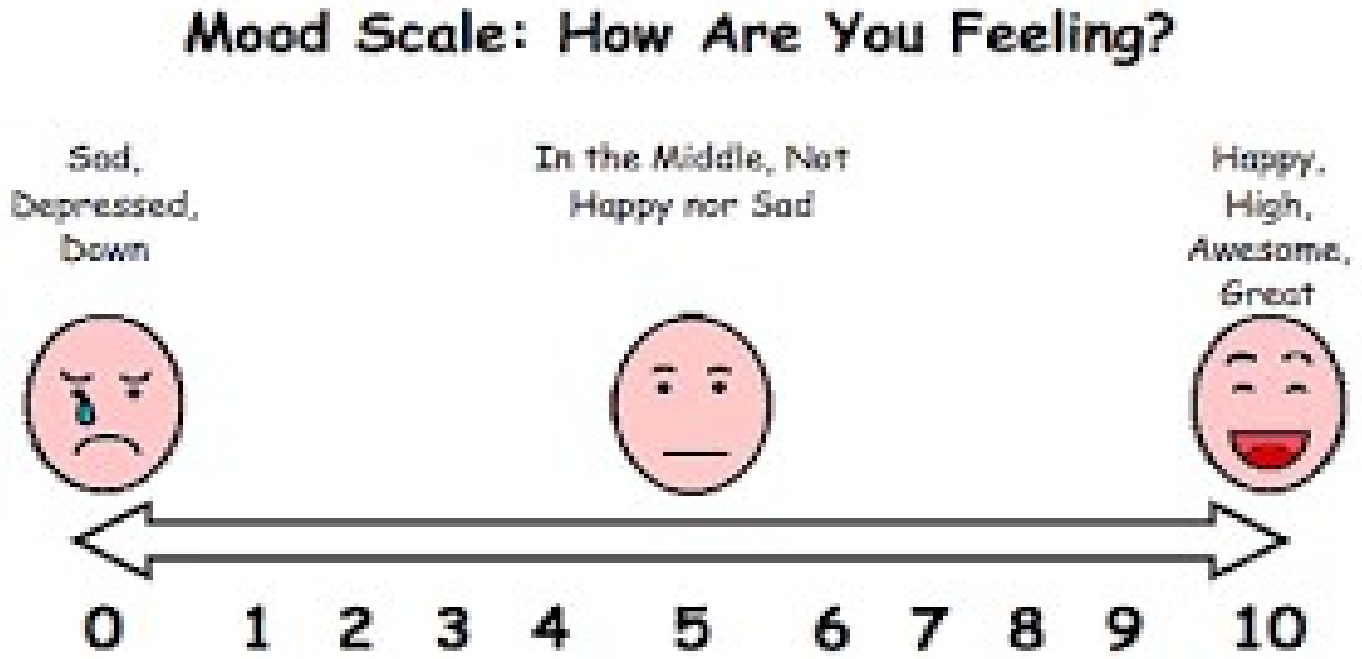
The physical production of speech, not the ideas.

- Rate: pressured, slowed, regular
- Tone
- Rhythm: rambling, staccato, musical
- Volume: whispered, mumbled, loud
- Language: fluent, simple, phrases, stilted (formal), garbled
- Accent/dialect
- Articulation: stuttering

Mood

The subjective, sustained, internal emotional state.

- Examples: hopeless, sad, dysphoric (sad with irritability), deflated, resigned, contemplative, terrified, annoyed, exasperated, embarrassed, anxious, guarded, euthymic, elevated, irritable, euphoric, playful, agitated, rageful.



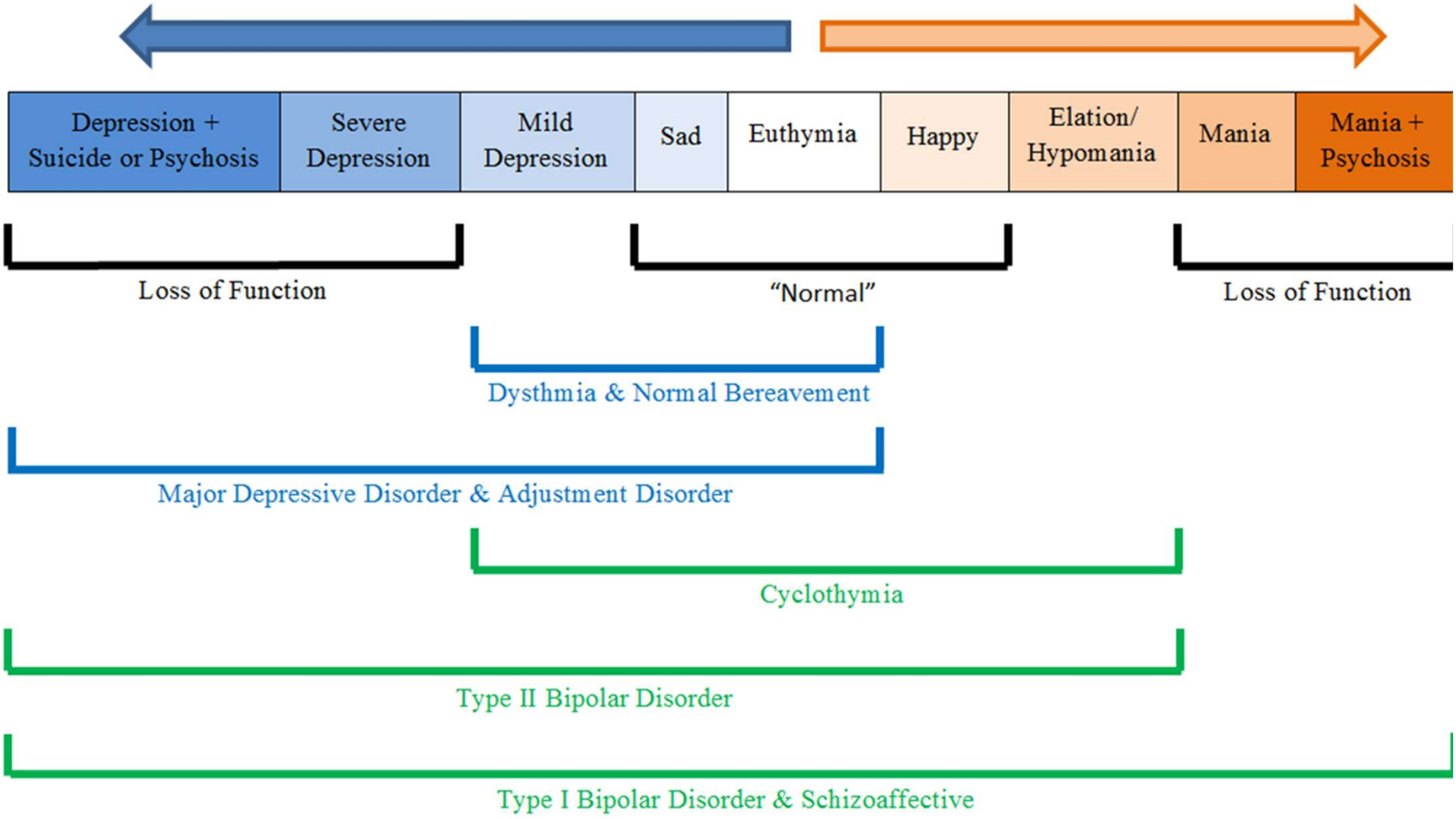
Disorders of Mood

Elevated mood:
mania/hypomania

Reduced mood: depression

- Anhedonia- inability to experience pleasure from activities usually found enjoyable, e.g. exercise, hobbies, music, sexual activities or social interactions
- Alexithymia- inability to describe or be aware of emotions

Disorders of Mood



Affect

The outward expression of emotion communicated (or not) through facial expression, vocal tone, posture, etc., as thoughts change.

- **Type of affect**: Euthymic, euphoric, neutral, dysphoric.
- **Quality/Range** describes the depth and range of the feelings shown. Parameters: flat (none)—blunted (shallow)—constricted (limited)—full (average)—intense (more than normal).

Affect

- **Motility** describes how quickly a person appears to shift emotional states.

  Parameters: sluggish—supple—labile.

- **Appropriateness** to content describes whether the affect is congruent with the subject of conversation or stated mood.

  Parameters: appropriate—not appropriate.

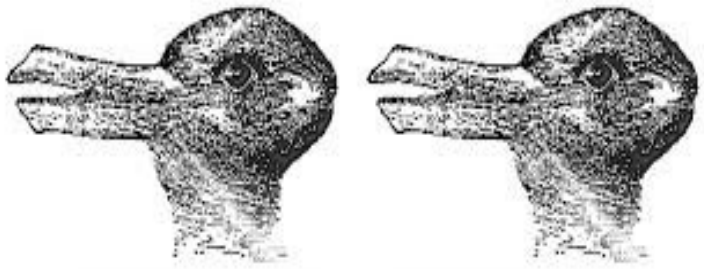
Perception

- **Illusions:** inaccurate perception of existing sensory stimuli.

(e.g., a wall appears as if it's moving, a drape by the window appears as if it's a man).

Perception

- **Optical illusions**



Perception

Alice in Wonderland Syndrome (AiWS)

- a neurological condition that affects human perception
  - micropsia,
  - macropsia
  - pelopsia,
  - teleopsia,
- size distortion of other sensory

modalities often associated with:

- migraines,
- brain tumors,
- use of the psychoactive drugs,
- the initial symptom of the Epstein–Barr virus

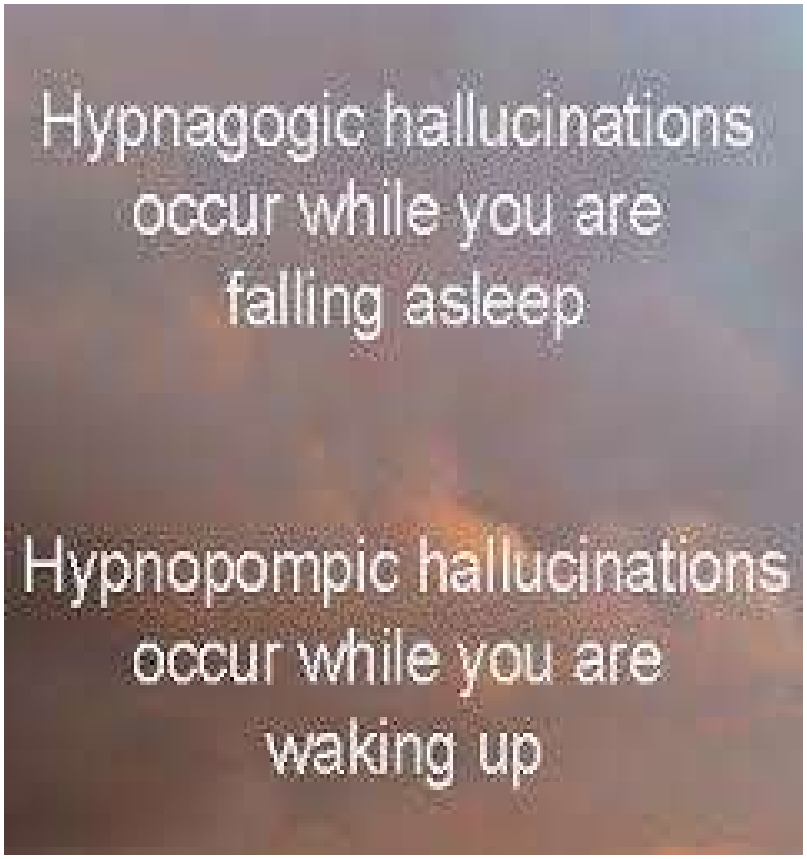
Perception

- **Hallucinations**: sensory experiences that occur in the absence of an actual stimulus.

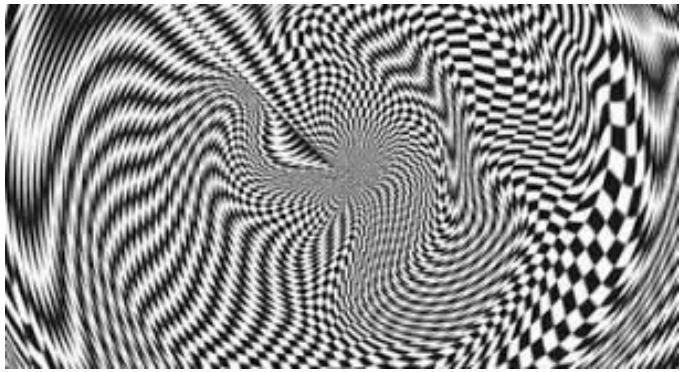
Types:

- Auditory
- Visual
- Gustatory: Taste
- Olfactory: Smell
- Kinesthetic: Motion
- Tactile: Touch

Perception


Hypnagogic hallucinations occur while you are falling asleep
Hypnopompic hallucinations occur while you are waking up

Visual hallucinations



Simple visual hallucinations (SVH)

- are also referred to as non-formed visual hallucinations and elementary visual hallucinations.
- SVHs are lights, colors, geometric shapes, and indiscrete objects.
- They can be further subdivided into:
  - phosphenes which are SVH without structure,
  - photopsias which are SVH with geometric structure

Complex visual hallucinations (CVH)

- are also referred to as formed visual hallucinations.
- CVHs are clear, lifelike images or scenes such as people, animals, objects, etc.

Tactile hallucinations

Formications (seen in Ekbom's syndrome(ES)=Delusional parasitosis)

- A sensation of small insects or bugs stinging, living, breeding and burning holes in the patient's skin.
- Organic and toxic syndromes can also induce tactile hallucinations.
  - The use of cocaine for recreational purposes has been reported to induce tactile hallucinations. They usually have sensations of moving itches and crawling insects.

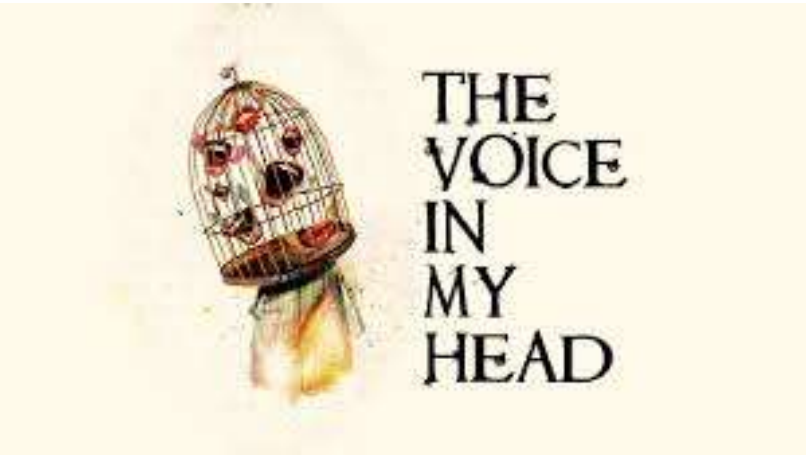
Tactile hallucinations

Phantom limb pain is a type of tactile hallucination because it creates a sensation of excruciating pain in a limb that has been amputated.

Kinesthetic hallucination a hallucination involving the sense of bodily movement e.g. rising or falling.

Cenesthetic hallucination describes a peculiar visceral or other bodily sensation that cannot be explained by reference to any known physiological mechanism e.g. a feeling of enlargement or contraction of internal organs.

Auditory hallucinations



- May be experienced as coming :
  - through the ears,
  - in the mind,
  - on the surface of the body,
  - anywhere in external space.
- The frequency can range from low (once a month or less) to continuously all day long.
- Loudness also varies, from whispers to shouts.
- The intensity and frequency of symptoms fluctuate during the illness → degree of interference with activities and mental functions.

Auditory hallucinations

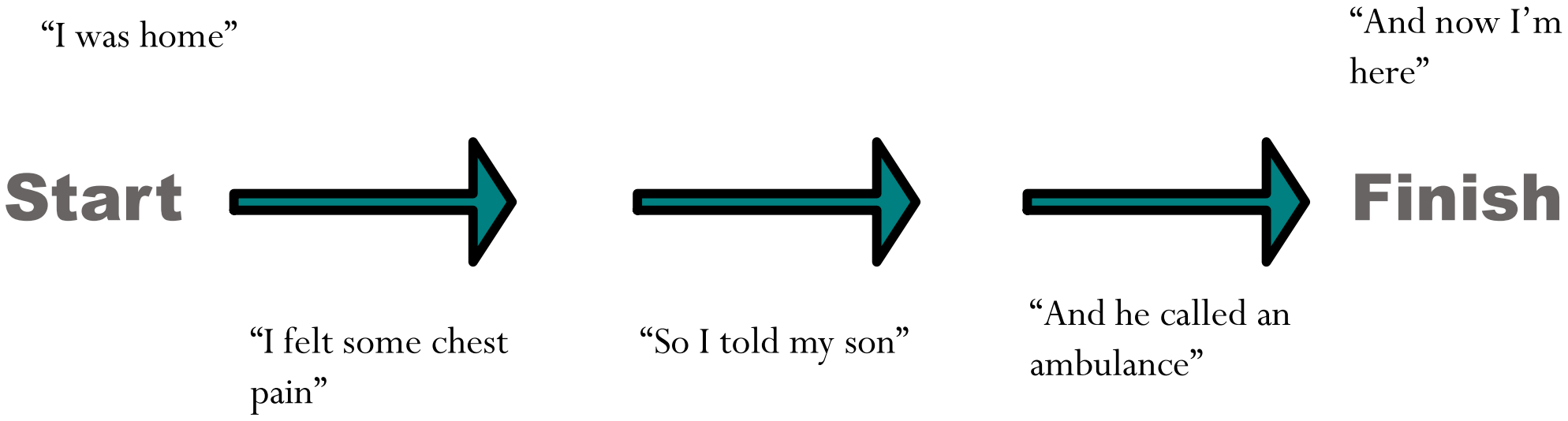
The most common type of auditory hallucinations in psychiatric illness consists of voices.

- Voices may be male or female. Patients who have auditory hallucinations usually hear more than one voice.
- Commenting and discussing voices are the first-rank symptoms and of diagnostic significance for schizophrenia!
- **Nonverbal hallucinations**, such as music, tapping, or animal sounds.
- **Functional hallucinations**, in which the person experiences auditory hallucinations simultaneously through another real noise (e.g., a person may perceive auditory hallucinations only when he hears a car engine).

Perception (Depersonalization & Derealization)

Thought Process

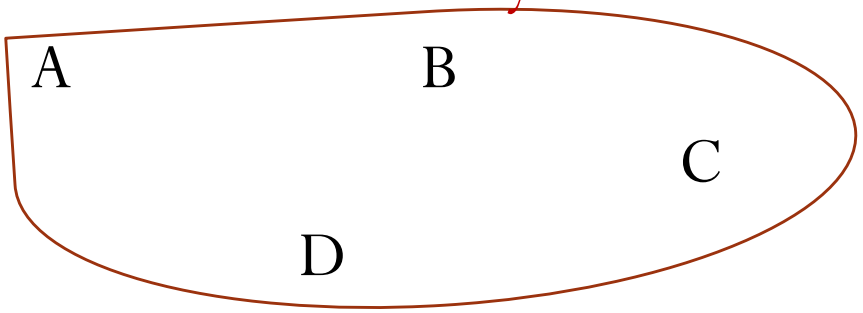
- The way in which ideas are linked, not the ideas themselves
- HOW the patient thinks, not WHAT
  - Ideal is linear, logical/coherent and goal directed



Thought Process

- Tangentiality - drifting off the subject, doesn't return to the initial topic
- X ---------- > a ---------- > s ----------> e

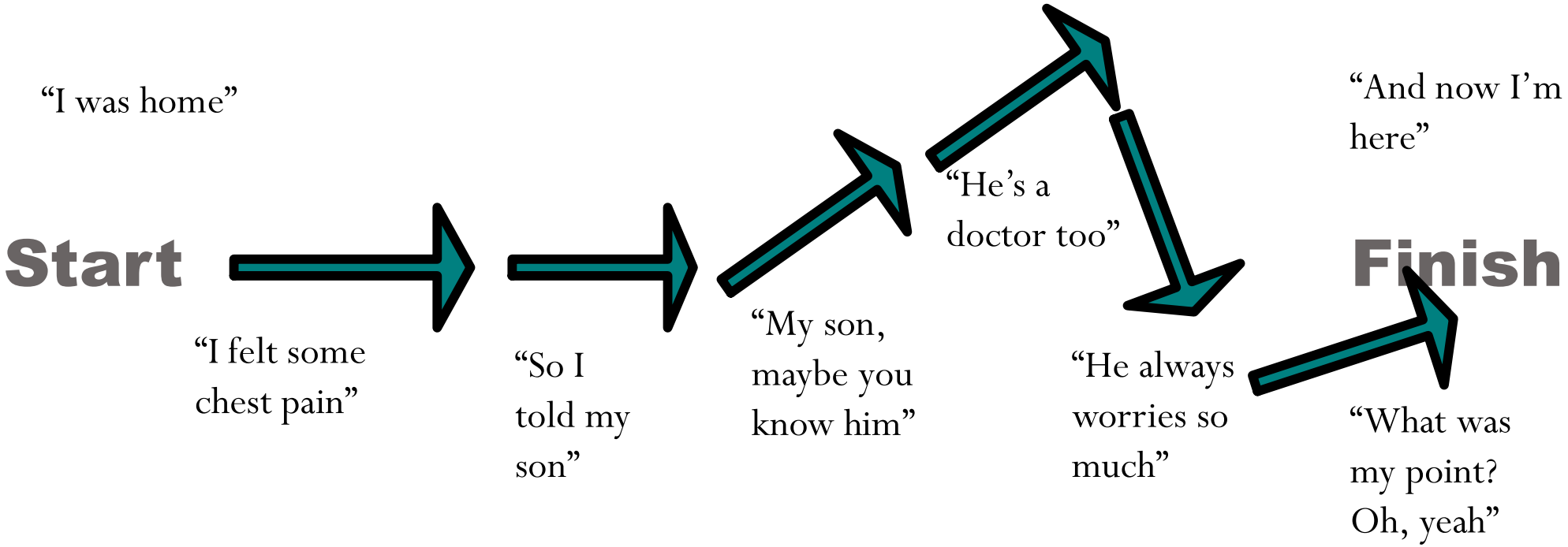
- Circumstantiality – comes back to the point



X ---------- >Y ---------- > Z ----------> X

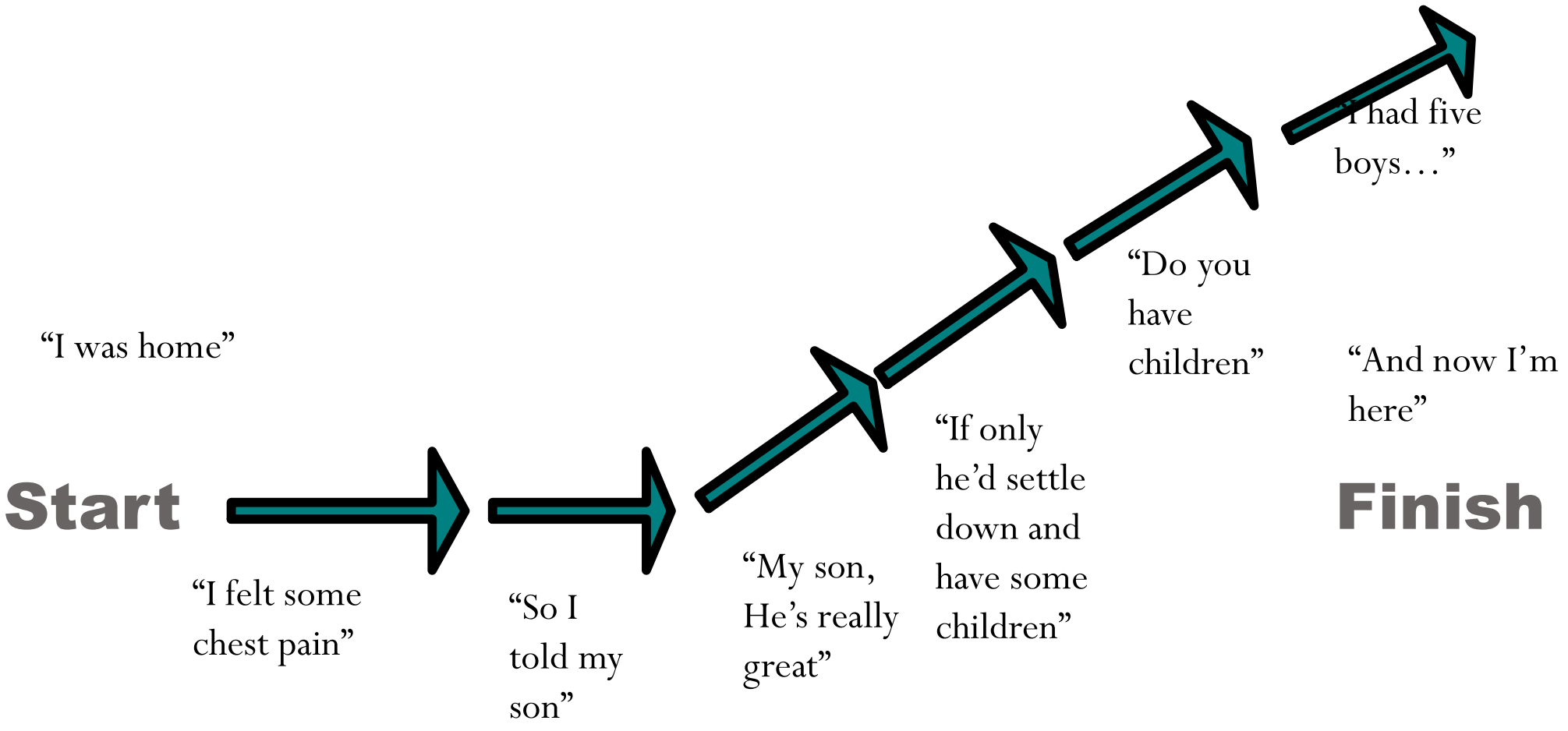
Thought Process

- Circumstantiality: overinclusion of trivial details that impede getting to the point.



Thought Process

- Loosening of associations: breakdown of *logical* connection between ideas and overall sense of goal-directedness. Words make sentences but don't make sense.



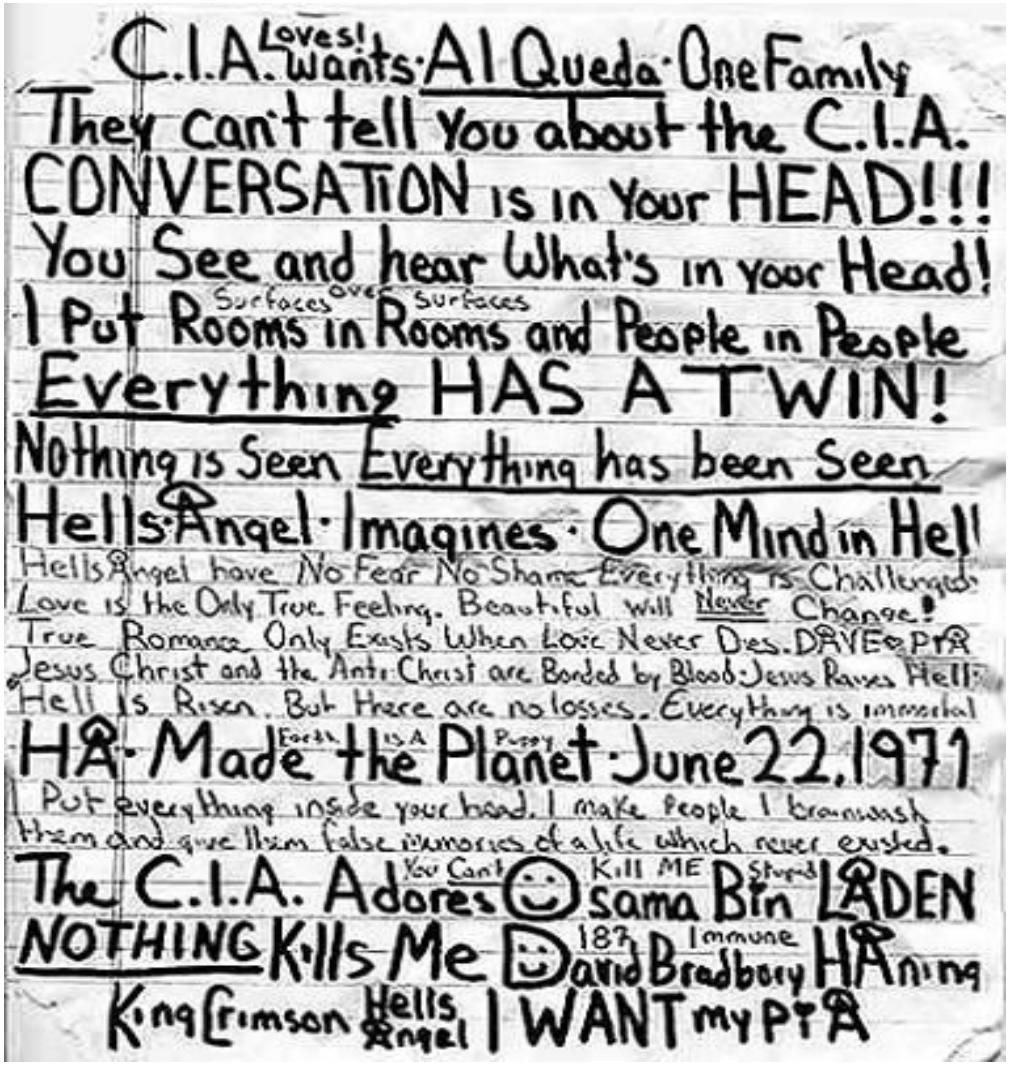
Thought Process

- Flight of ideas: a succession of multiple associations moving abruptly from idea to idea, usually through rapid, pressured speech.
- Thought blocking: a sudden disruption of thought or break in the flow of ideas.
- Poverty of thought: alogia → poverty of speech.
- Concrete thinking: literalness of expression and understanding, with failed abstraction. Can be tested by the use of proverbs.

Thought Process

- Perseveration: the repetition of a particular response, such as a word, phrase, or gesture, despite the absence or cessation of a stimulus.
- Verbigeration: an obsessive repetition of meaningless words and phrases.
- Neologisms: words and phrases are invented by the patient or new meaning to a known word is given.
- Clang associations: Word connections due to phonetics rather than actual meaning. “My car is red. I’ve been in bed. It hurts my head.”
- Word salad: Incoherent collection of words.

Thought Process – word salad

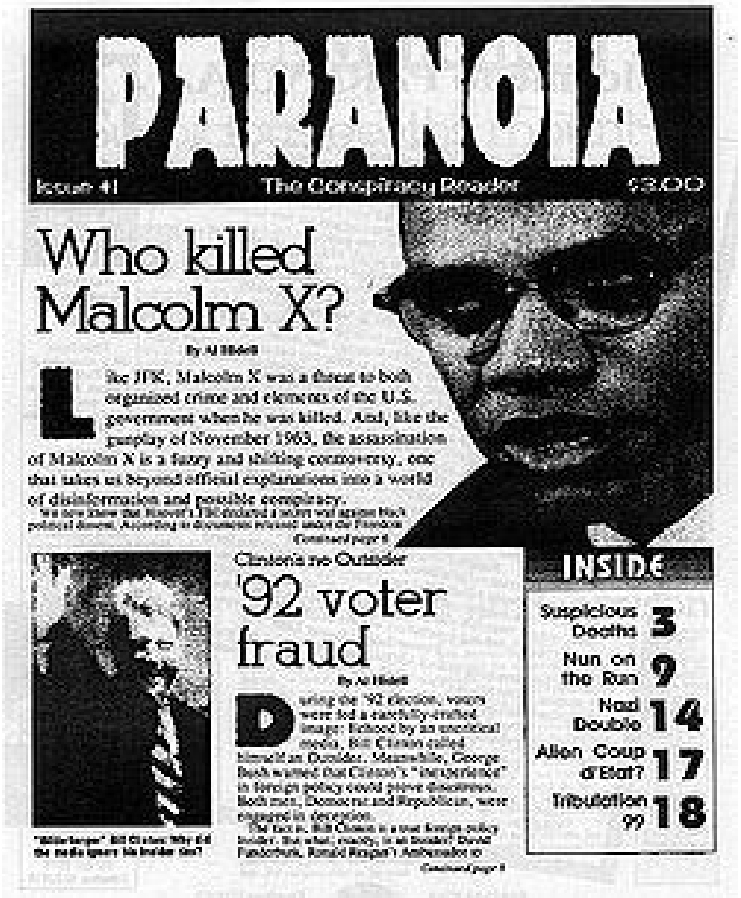


Thought Content

- The patient's ideas
- WHAT the patient thinks, not HOW

Thought Content

- **Delusions**



- Fixed, false beliefs that are not shared by the person's culture and cannot be changed by reasoning

Delusions

- **Certainty**: Individuals that hold delusions are certain in their beliefs; they believe with 100% conviction that they are real, despite significant logical evidence to the contrary.

- **Incorrigibility**: Those with delusions will not update their false beliefs even if presented with overwhelming logical evidence suggesting that the opposite is true.

- **Impossibility**: The delusion that a person holds is not only untrue but generally impossible or highly implausible to be true. Some of the delusions may not only seem like an obvious impossibility, but they may seem highly bizarre.

Delusions

- Persecutory delusions: belief that one is being persecuted
- Delusions of litigation: a person takes incessant litigious actions intended to obtain legal remedies for perceived wrongs that appear trivial or insignificant to others (paranoia querulans)
- Megalomanic (grandiose): belief that one has special powers or is someone important (Jesus, President), has noble origin, supernatural skills and strength.
- Depressive (melancholic): d. of guilt and worthlessness, nihilistic d., hypochondriacal, catastrophic

Delusions

Concerning the possession of thoughts :

- Thought insertion: delusion that thoughts are being implanted in one's mind by other people or forces
- Thought withdrawal: delusion that thoughts are being removed from one's mind by other people or forces
- Thought broadcasting: belief that one's thoughts can be heard by others

Delusional misidentification syndromes

Capgras' delusion – a person holds a delusion that a friend, spouse, parent, or another close family member (or pet) has been replaced by an identical-looking impostor.

"*A 74-year-old married housewife believed that another unrelated man had replaced her husband. She refused to sleep with the imposter, locked her bedroom at night, asked her son for a gun, and finally fought with the police when attempts were made to hospitalize her. She easily recognized other family members and would misidentify her husband only.*"

Intermetamorphosis is the belief that people in the environment swap identities with each other whilst maintaining the same. appearance.

Fregoli's delusion is the belief that various people the believer meets are the same person in disguise.

Delusions

De Clérambault's syndrome – "erotomania"

Commonly seen in women who are convinced that a man, usually older, of higher status, e.g., the consultant is in love with her.

Othello's syndrome

A person is preoccupied with the thought that their spouse or sexual partner is unfaithful without any real proof.

Delusional parasitosis

A strong belief that a patient is infected with parasites,

often associated with a sensation known as formication.

Delusions

Cotard syndrome

- Nihilistic delusions, esp. in psychotic depression
  - *"I've got no blood / bowels / breath / money"*
  - *"I'm dead / rotting from inside"*

Induced delusional disorder (folie a deux)

- Delusion is shared by people with close emotional links
- Only one person suffers from a genuine psychotic disorder
- The other person's delusion disappears when they are separate

Thought content

- Magical thinking: a clinical term is used to describe a wide variety of nonscientific and sometimes irrational beliefs.
  - These beliefs are generally centred on correlations between events and express irrational cause-and-effect string.

  - *„If I dress in a red dress my neighbour will stop quarrelling with his wife."*

Thought content

- Symbolic thinking: involves assigning special, symbolic meaning to things, people, and situations that are objectively neutral.
  - *„99% of things mean something to me. The white colour symbolizes something, while the yellow one does not. I seek the number 7 everywhere. It has a special meaning to me. When I see 7 everything goes perfect to me."*

Thought content

- Ideas of reference: a belief that some event is uniquely related to the patient (e.g., a TV show character is sending patient messages)

- Overvalued ideas: preoccupations which can come to dominate (& ruin) a person's life, but you can understand where they came from, and it's sort of believable.

Thought content

- Obsessions / compulsions

Compulsions

- repetitive, rule-based behavior that a person feels they must perform in order to feel normal and in some cases to prevent negative consequences from happening.
- it is an impulse to repeatedly perform an act even if it doesn't seem rational or goes against an individual's will.
- can be ritualized and follow a pattern

-checking

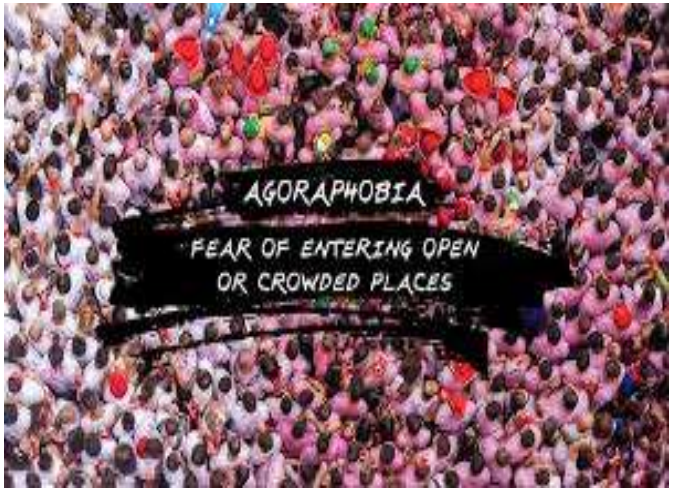
-counting

-repeating

-washing

Thought content

- Phobias: persistent, irrational fears

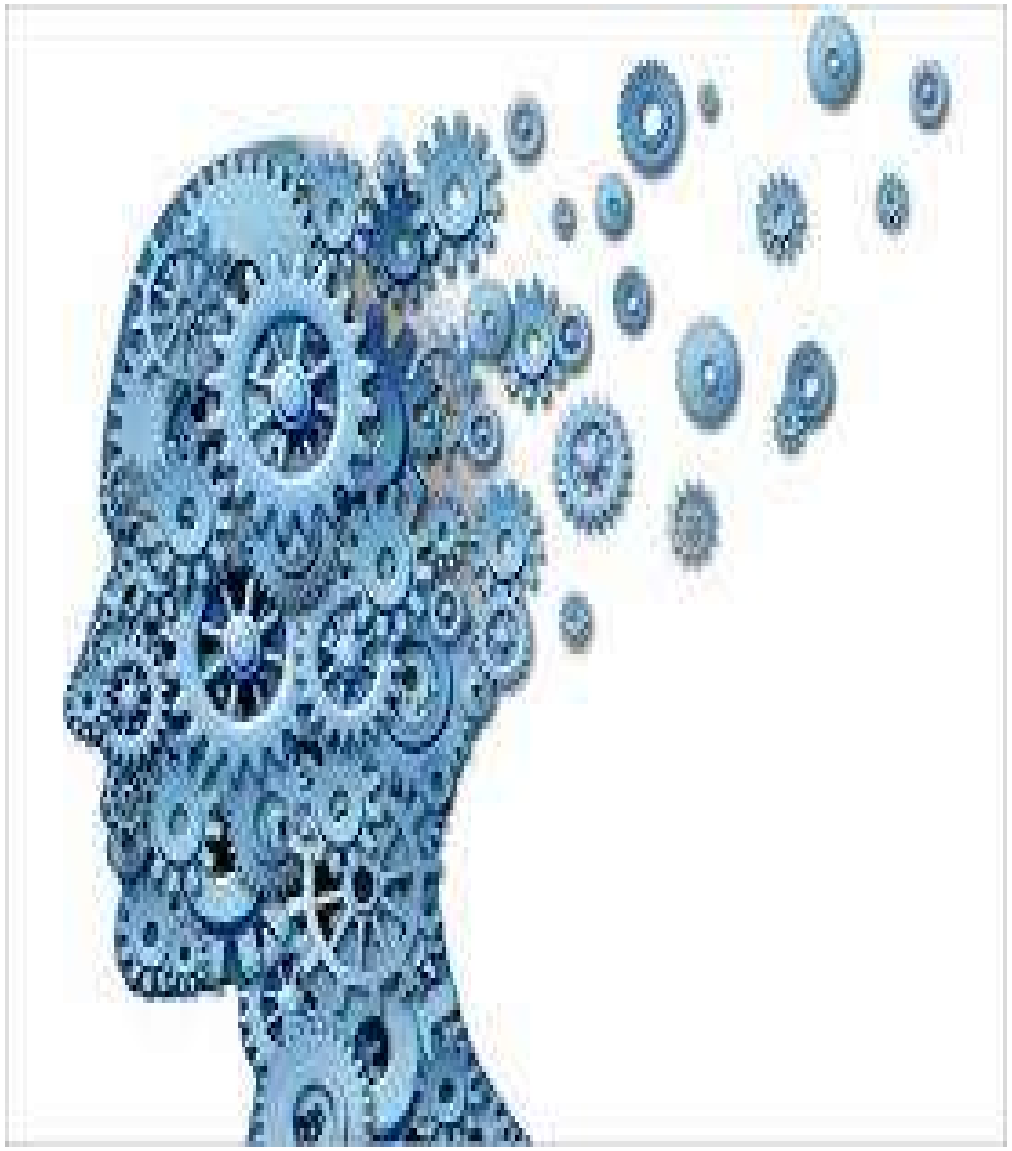


Thought content

- Suicidal and homicidal ideation

Sensorium and cognition

- Organic brain function
- Intelligence
- Capacity for abstract thought
- Levels of insight and judgement



Sensorium and cognition

Consciousness is awareness of the self and the environment.

Disorders of consciousness:

- qualitative
- quantitative
  - short-term
  - long-term

Quantitative changes of consciousness

Somnolence- is a state of a strong desire for sleep or sleeping for unusually long periods.

Sopor- a condition of abnormally deep sleep or a stupor from which it is difficult to rouse. It involves a profound depression of consciousness, manifested by drowsiness while maintaining coordinated defensive reactions to stimuli such as pain, harsh sound, bright light, and preserving vital functions.

Coma- a state of unconsciousness in which a person:

- cannot be awakened;
- fails to respond typically to painful stimuli, light, or sound;
- lacks a normal sleep-wake cycle,
- does not initiate voluntary actions.

Qualitative changes of consciousness

Delirium or acute confusional state

an organically caused decline from a previously attained baseline level of cognitive function

It is characterised by:

- fluctuating course
- attentional, perceptual and cognitive deficits
- generalised severe disorganization of behavior
- changes in arousal (hyperactive, hypoactive, or mixed),
- altered sleep-wake cycle,
- psychotic features such as hallucinations and delusions

It is not a disease, but rather a clinical syndrome (a set of symptoms) which may result from:

- an underlying disease

-drugs administered during treatment

- withdrawal from drugs,

- varying combinations of two or more of these factors

Sensorium and cognition

- Consciousness (alert, somnolent, stuporous, comatose)
- Orientation (as to time, place, person)
- Memory (immediate, recent, recent past, remote)
- Concentration and attention (subtracting serial 7s from 100)
- Reading and writing
- Visuospatial ability (copy the face of a clock, interlocking shapes)
- Abstract thoughts
- Information and intelligence

Quantitative memory dysfunctions

- Amnesia: a loss of memory caused by
  - Brain damage
  - Disease
  - Psychological trauma
  - Sedative and hypnotic drugs
- Anterograde amnesia refers to the inability to create new memories due to brain damage, while long-term memories from before the event remain intact
- Retrograde amnesia refers to the inability to recall memories before the onset of amnesia
- Hypomnesia- abnormally poor memory of the past
- Hypermnesia- usually vivid memory

Qualitative memory dysfunctions

- Déjà vu is a French term which literally means „*already seen*”, a phenomenon of having the strong sensation that an event or experience has already been experienced.
  - two-thirds of the population have had déjà vu
  - temporal lobe epilepsy (strongest association)

- Déjà vecu is the feeling of having "*already lived through*" something

- Jamais vu is often described as the opposite of déjà vu and means "*never seen*". It involves a sense of eeriness and the observer's impression of seeing the situation for the first time, despite rationally knowing that he or she has been in the situation before.

- Jamais vecu is the feeling of having "*never lived through*" something

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Attention

- Focused attention: The ability to respond discretely to specific visual, auditory or tactile stimuli.
- Sustained attention (vigilance and concentration): The ability to maintain a consistent behavioral response during continuous and repetitive activity.
- Selective attention: The ability to maintain a behavioral or cognitive set in the face of distracting or competing stimuli.
- Alternating attention: The ability of mental flexibility that allows individuals to shift their focus of attention and move between tasks having different cognitive requirements.
- Divided attention: This is the highest level of attention and it refers to the ability to respond simultaneously to multiple tasks or multiple-task demands.

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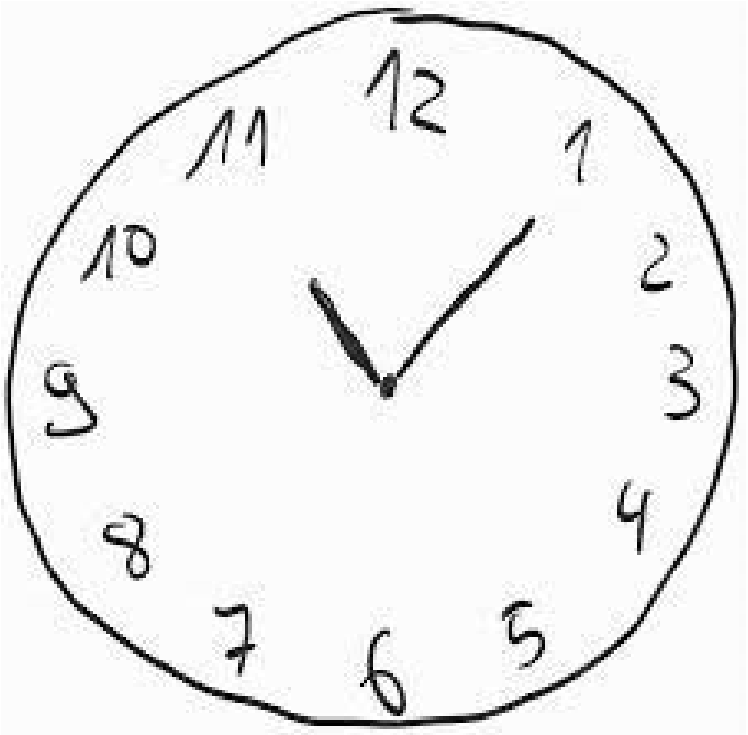
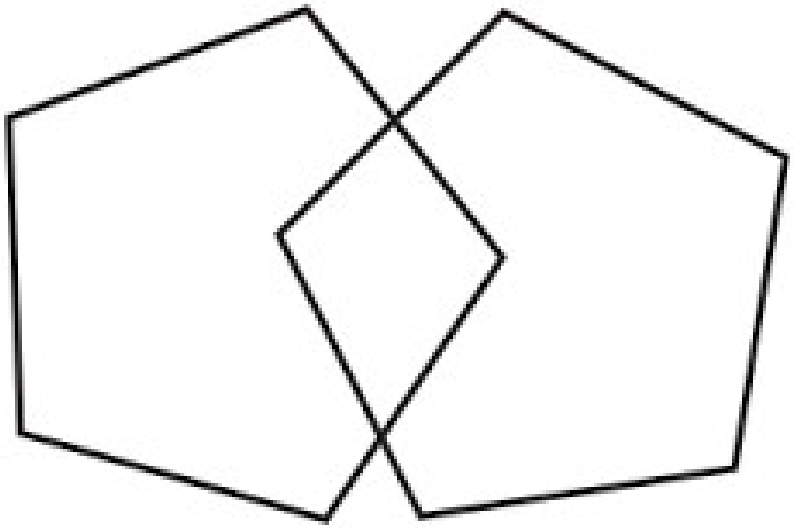
Visuospatial ability





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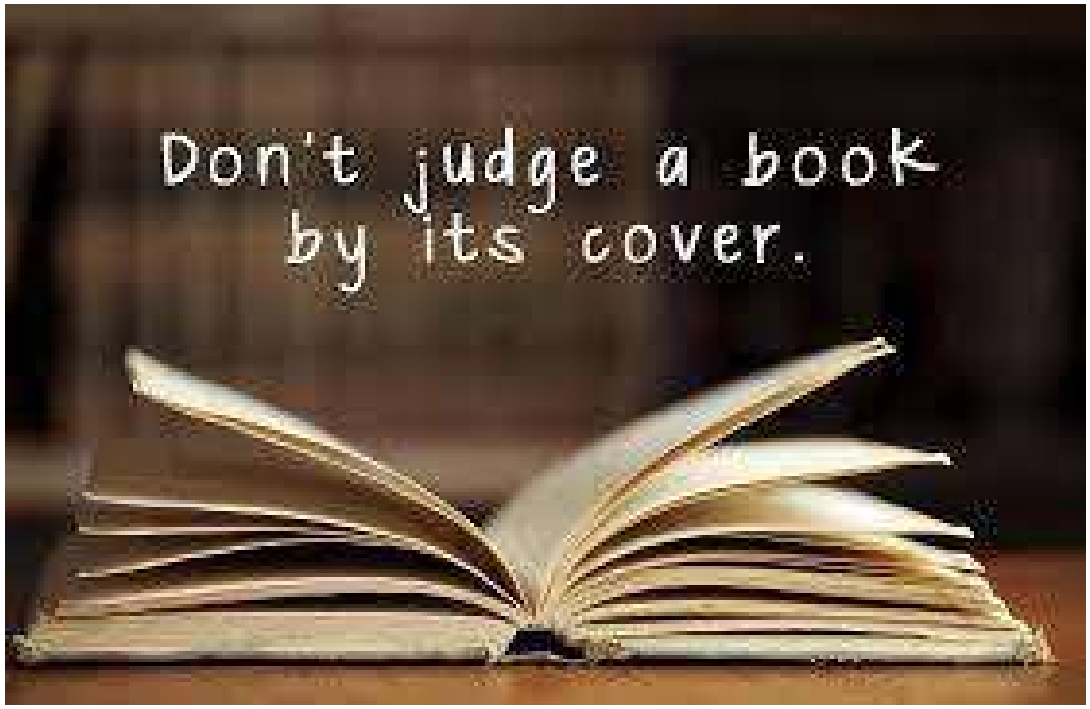
Abstract thoughts

How are an apple and orange alike?

Normal answer: "*They are fruits*."
Concrete answer: " *They are round*."

Abstract thoughts



Normal answer: " *You can't judge people just by how they look.*"
Concrete answer: " *Books have different covers.*"

Sensorium and cognition

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Intelligence Disorders

Intelligence- the ability to perceive information, and retain it as knowledge to be applied towards adaptive behaviors within an environment.

Intelligence quotient (IQ):

IQ = (mental age / calendar age) x 100

IQ scores

- Very superior: >130
- Superior: 120–129
- High average: 110–119
- Average: **90–109**
- Low average: 80–89
- Borderline: 70–79
- Extremely low (intellectual disability): **<70**

50-69	mild (9-12 years)
35-49	moderate (6-9 years)
20-34	severe (3-6 years)
< 20	profound (< 3 years)

Intelligence Disorders

Disorders of intellect:

- Mental retardation- a **neurodevelopmental** disorder characterized by significantly impaired intellectual and adaptive functioning. It is defined by an IQ score under 70 in addition to deficits in two or more adaptive behaviors that affect the everyday, general living.

- Dementia- a group of symptoms resulting from brain diseases (**neurodegeneration**) that cause a long term and often gradual decrease in the ability to think and remember that is great enough to affect a person's daily functioning.

Motor Disorders

quantitative:

- hypoagility
- hyperagility
- agitated behaviour

qualitative:

- mannerisms
- stereotypies
- posturing
- waxy flexibility
- echopraxia
- schizophrenic impulse
- negativism
- short-circuit behaviour
- automatism
- agitation
- tics
- abulia

Motor disorders in catatonia

- stupor (i.e., no psychomotor activity; not actively relating to the environment)
- catalepsy aka waxy flexibility (i.e., passive induction of a posture held against gravity, a patient allows positioning by the examiner and maintains position)
- negativism (i.e., opposition or no response to instructions or external stimuli)
- posturing (i.e., spontaneous and active maintenance of a posture against gravity)
- mannerism (i.e., odd, circumstantial caricature of normal actions)
- stereotypy (i.e., repetitive, abnormally frequent, non-goal-directed movements)
- grimacing (i.e., odd, circumstantial caricature of normal facial expression)
- echopraxia (i.e., mimicking another's movements)

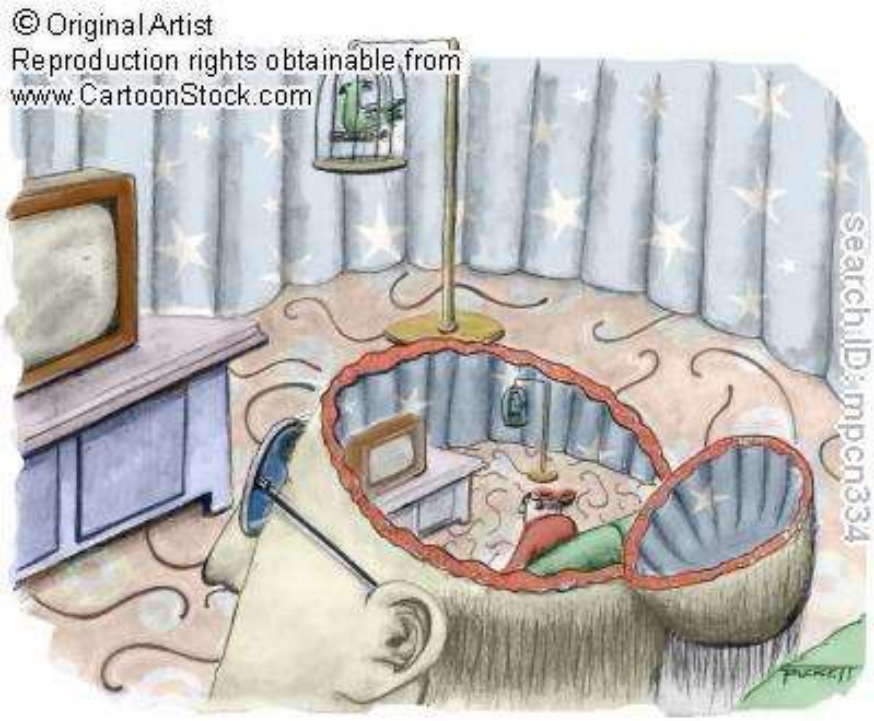
Motor disorders

- Cataplexy
  - a sudden and transient episode of muscle weakness accompanied by full conscious awareness,
  - typically triggered by emotions such as laughing, crying, or terror
  - the cardinal symptom of narcolepsy with cataplexy affecting roughly 70% of people who have narcolepsy

do not confound with catalepsy !!!

Insight / Judgment

- Insight: patient's understanding of his/her illness



- Judgment: can the patient recognize and comply with social norms
  - Good, fair, limited, marginal, poor.

Major Depression

- GA: Plain, casual dress, cooperative but detached, slumped and at times staring into the distance
- Speech: increased latency, low volume, occasional sighs and diminished
- Mood: hopeless, dysphoric
- Affect: constricted
- TP: linear but delayed and lacking detail
- TC: preoccupation with guilt and worthlessness. Passive SI but no HI. No delusions but guilt verging on excessive.
- Insight: fair Judgment: fair

Bipolar Mania

- GA: dressed in wrinkled dress shirt and slacks, sitting at edge of seat
- Speech: loud, emphatic, pressured, often interrupting a sentence with another.
- Mood: dismissive, euphoric
- Affect: expansive, labile
- TP: tangential to flight of ideas
- TC: theme of intellectual superiority and annoyance at being here, wants to work on business ventures. Delusions of wealth. No SI or HI. Plan of leaving and getting funds from NASA or the governor.
- Insight: poor Judgment: impaired

Paranoid Schizophrenia

- GA: Casual, clean dress and adequate hygiene, sitting at edge of seat with arms crossed, seen scanning the room
- Attitude: defensive, guarded
- Speech: low volume and measured but otherwise fluent
- Mood: "I'm fine" but appears indignant
- Affect: constricted but quietly irritable
- TP: linear goal-directed
- TC: delusions of persecution by the Mexican mafia via implanted devices in his eyes and ultrasonic waves. No SI or HI and denies AH and VH although he reports the "waves" turn to messages from the mafia. He wants to mafia to stop their activities but will stay at his B & C and will resume his meds in the meantime.
- Insight/Judgment: poor/limited

Social Anxiety Disorder

- GA: casual, plain dress, good grooming, avoidant eye contact, arms crossed but fidgety.
- Speech: low volume, hesitant tone, at times stammering.
- Mood: anxious, nervous
- Affect: constricted with an occasional nervous laugh
- TP: linear albeit at times on a tangent
- TC: theme of discomfort around people, hoping for interview to end. No delusions, SI, HI.
- Insight: good Judgment: good

General psychopathology
Q&A

1. A 32-year-old woman is seen in an outpatient psychiatric clinic for the chief complaint of a depressed mood for 4 months. During the interview, **she gives very long, complicated explanations and many unnecessary details before finally answering the original questions.** Which of the following psychiatric findings best describes this style of train of thought?

a. Loose association

b. Circumstantiality

c. Neologism

d. Perseveration

e. Flight of ideas

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2. A 56-year-old man has been hospitalized for a myocardial infarction. Two days after admission, he awakens in the middle of the night and screams that there is a man standing by the window in his room. When the nurse enters the room and turns on a light, **the patient is relieved to learn that the "man" was actually a drape by the window**. This misperception of reality is best described by which of the following psychiatric terms?

a. Delusion

b. Hallucination

c. Illusion

d. Projection

e. Dementia

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3. An 18-year-old man is brought to the emergency room by the police after he is found walking along the edge of a high building. In the emergency room, he mumbles to himself and appears to be responding to internal stimuli. When asked open-ended questions, **he suddenly stops his answer in the middle of a sentence, as if he has forgotten what to say**. Which of the following symptoms best describes this last behavior?

a. Incongruent affect

b. Thought blocking

c. Perseveration

d. Tangentiality

e. Thought insertion

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4. A 26-year-old woman with panic disorder notes that during the middle of one of her attacks, **she feels as if she is disconnected from the world, as though it were artificial or distant**. Which of the following terms best describes this symptom?

a. Mental status change

b. Illusion

c. Retardation of thought

d. Depersonalization

e. Derealization

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c. Retardation of thought

d. Depersonalization

e. Derealization

5. A 62-year-old man is arrested for disturbing people on their way to work by insisting they take his prepared reading materials with them. The topic of the materials was the man's special communications with God and his instructions for following him on a special path to heaven.

a. Erotomanic

b. Grandiose

c. Jealous

d. Persecutory

e. Somatic

f. Mixed

g. Unspecified

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c. Jealous

d. Persecutory

e. Somatic

f. Mixed

g. Unspecified

Thank you ☺