MEDD 421 Clinical Skills
2019-2020
Psychiatry Student Guide

Table of Contents

ACKNOWLEDGEMENTS

We are grateful to
Dr. Michael Cooper, Dr. Clare Beasley, Dr. Marilyn Champage, Dr. Randall White
Dr. Elton Ngan, Dr. Jon Fleming, Dr. Bill Maurice
and their colleagues in the UBC Dept.of Psychiatry

INTRODUCTION

The psychiatric interview is very complex and takes many years to master. This guide will focus on beginning learners and the basic building blocks of the interview. Second year medical students will have an opportunity to practice these skills with standardized and volunteer patients. Students will progress to a more advanced psychiatric interview in third year when doing the clinical clerkship in psychiatry.

Some patients and situations will always present great difficulties. The most important thing is to maintain an attitude of respectful attentiveness and concern. Using empathic comments appropriately, even when patients are angry and challenging, will always be the best approach. The skills you learn doing the psychiatric interview will benefit your history taking in all of your medical and surgical rotations and will provide a foundation for professionalism for the rest of your career.

The most important learning point is using the structure of mood, thoughts, and behaviour to guide the interview process. Almost all psychiatric disorders can be described by these 3 categories. Using a logical structure instead of a mnemonic (e.g. SIG E CAPS) will ensure a more effective interview.

ORGANIZATION

Each student will participate in three Psychiatric Clinical Skills sessions as part of MEDD 421. For the most part, tutors will be psychiatrists, but some sessions may be taught by other clinicians (psychologists, mental health workers, psychiatric registered nurses). Efforts will be made to ensure group/tutor continuity across sessions.

Before the start of the interview, the interviewing student will be paired with another student who will take notes. The **note-taker** will present the history after the interview and will be responsible for writing up a full case report. The case report must be emailed or given to the supervisor the following week. The **interviewer** will present the mental status exam. The other students will be assigned to either doing a biopsychosocial formulation or doing an empathy checklist.

For students doing the **biopsychosocial formulation**, please see the blank grid in appendix 2. Be sure to bring a printed form to the session. You only need to make very brief notes in the appropriate boxes as the interview proceeds. You might have additional notes to add when the case presentation is being done. The formulation will be discussed as a group.

For students doing the **empathy checklist,** please bring a printed copy of the form in appendix 3. Listen carefully to the interview and make a brief note in the appropriate boxes when the interviewing student makes an empathic comment or behaviour. The empathy checklist will be discussed as a group.

Session 1: Students will practice/observe psychiatric interviewing using Standardized Patients. Cases have been developed to facilitate interviewing and conducting a mental status examination.

Session 2 & 3: Students will practice /observe psychiatric interviewing and mental status examination on appropriate psychiatric in/outpatients.

Each group should have the opportunity to observe an interview with a patient who demonstrates Major Depressive Disorder (MDD) and a patient who demonstrates a psychotic disorder. In addition, if time permits, it is hoped that there will be opportunities to observe interviews of patients with other DSM-5 disorders.

All students are expected to have at least one opportunity to participate in a (supervised) psychiatric interview on a patient, and to present the history and mental status examination. This comprehensive guide contains information on how to perform a psychiatric interview. Each student will be required to submit a written Case Report.

Case Report: Over the 3 weeks, each student will be required to submit 1 case write up to their tutor. The case report for these introductory sessions should be a brief 2- to 3-page summary that follows the headings in this guide. Psychiatric reports follow a narrative style for the identifying data, history of presenting problem, and mental status examination. Point form may be used for the other sections. Please see appendix 1 for a sample case report.

The case report concludes with three additional sections:

- Diagnostic classification based on DSM5—this includes the working diagnosis and relevant differential diagnoses
- Biopsychosocial formulation
- Treatment plan

PLEASE NOTE: For all Case Write Ups, students are NOT to use any patient names, identifiers, birth date or address. For confidentiality purposes, please refer to patient as 'patient A' (or pick any letter) in all write ups.

*****Write ups will need to be encrypted, password protected and emailed to your tutor. Passwords should NOT be emailed. Please confirm password with your preceptor during the session. Encryption guidelines can be found at:**
https://cio.ubc.ca/sites/cio.ubc.ca/files/documents/resources/How%20to%20Encrypt%20Files%20using%20Common%20Applications%20Guideline.pdf

PREPARATION

Required Readings / Review

- Bates' Guide to Physical Examination & History Taking, latest edition. Chapter 5: Behaviour & Mental Status
- MEDD 411 Communication Skills "The Patient Centred History" and "Interviewing Skills Guidelines" (available on Entrada).

Required Viewings

- Introduction to Psychiatric Interviewing (47 min) [Also available on Entrada>MEDD 421>Clinical Skills>]
  Rachel Video - Introduction to Psychiatric Interviewing

Suggested Resources (including other texts, websites, course material, etc.)

- The general psychiatry textbook recommended is Kaplan & Sadock, Synopsis of Psychiatry, 11th ed.
  Chapter 5.1 - Psychiatric Interview, History, and Mental Status Examination
  Chapter 5.2 - The Psychiatric Report and Medical Record
  Chapter 5.9 - Physical Examination of the Psychiatric Patient
  Chapter 6 - Classification in Psychiatry
- In addition to the above, students may wish to refer to Psychiatric Interviewing: The Art of Understanding 2nd edition by Shawn Christopher Shea, MD (W.B. Saunders Company, 1998) or Psychiatric Clinical Skills by David S Goldbloom, MD (Centre for Addiction and Mental Health, 2011).
- Students may also with to review the following online video modules (external content):
  1) The Mental Status Exam http://aitlvideo.uc.edu/aitl/MSE/MSEkm.swf
  2) The Psychiatric Interview, 2013: A Self-Directed Learning Module http://www.admsep.org/csi-emodules.php?c=psych-interview&v=y

OBJECTIVES

On completion of these three sessions, students should:

1.Demonstrate the introduction of the psychiatric interview to the patient including addressing confidentiality and explaining the purpose.
2. Demonstrate empathetic techniques to build rapport including attentive listening, verbal and non-verbal facilitation, summary statements, mirroring, and empathetic comments.
3. Systematically, explore mood, thoughts, and behaviour during the History of Present Illness (HPI).
4. Explore somatic symptoms relevant to psychiatric disorders as part of the HPI including concentration, pain, appetite, energy, and sleep.
5. Use the main headings of the psychiatric interview to guide the remainder of the interview and ensure all key areas are covered: Identifying Data, Chief Complaint, Medications, Past Medical History, Review of Systems, Past Psychiatric History, Substance Use, and Personal History.
6. Perform a Mental Status Examination that includes Appearance and General Behaviour, Accessibility, Speech and Language, Mood and Affect, Thought Content and Process, Perceptions, Cognition, Insight, and Judgment.
7. Differentiate between mood disorders and disorders of thought form and content (psychosis).
8. Present the "History of the Current Episode" from the data in the interview and a comprehensive mental status examination following a patient interview.
9. Present a biopsychosocial formulation from the data in the interview using a grid with predisposing, precipitating, perpetuating, and supportive factors.
10. Submit a written Case Report after session 2 or session 3.

EQUIPMENT

- UBC Student ID
- Please **do not** wear your white coats.

ASSESSMENT & EVALUATION *(when required)*

Student Assessment

Students will be formally assessed during Clinical Skills using Workplace Based Assessments (WBAs).

A WBA will occur at the end of **Psychiatry Session 3 in MEDD 421**.

Your tutor will be asked to assess whether or not you are performing the Psychiatric exam below, at, or above the appropriate milestone level for a second-year medical student.

In MEDD421:
The student can list the basic components of the psychiatric history. They have presented the "history of the current episode" and mental state exam following at least one interview of a real or simulated patient.

Your tutor will also be asked to comment on your professionalism.

Time will be allotted during your Clinical Skills sessions for feedback and WBA completion – **it is strongly encouraged that you review the WBA directly with your tutor at this time**.

Tutor Evaluation

As part of your professional commitment, you may be required to complete an online assessment of your tutor and a course evaluation on One45.

TECHNIQUE

1. INTRODUCTION

The interview starts before you greet the patient. Make sure that the room is set up properly and that privacy is assured. If possible, position the chairs at a ninety-degree angle so that you are not face-to-face with the patient. Ensure a comfortable distance between the chairs—roughly 2 to 3 feet. When the patient arrives, or is brought in, make sure that they are comfortable. Start by introducing yourself and then explain the process and obtain consent. Emphasize that this interview is confidential but that if any safety concerns come up you will need to discuss them with your supervisor.

Before getting to the HPI, we need a bit of context. For an initial interview, especially in an outpatient clinic, it is generally best to start by asking the patient to provide a few basic details about themselves:

- How would you like me to address you? (It may be important to clarify how the patient self-identifies, especially with regard to gender. Be sure to use the most appropriate terminology. Gender identity is a complex issue and is beyond the scope of this introductory guide. Students are encouraged to develop an understanding of this issue as they advance through their training.)
- How old are you? (For older patients, it may be more sensitive to ask, “May I ask your age?”)
- What is your living situation? Who lives with you? What part of town do you live in? What sort of place do you live in?
- What is your marital status? Are you in a relationship?
- How do you support yourself?

Ethnic and cultural background is best left to the personal history section.

You only need to spend a couple of minutes on this. If the patient wants to go into more detail, gently suggest that you discuss this a bit later.

Sometimes patients will disclose a significant death or loss at this stage. For example, if their spouse has died, you will need to respond empathically. Generally, you should not offer a sympathetic response such as "I'm sorry for your loss.” This often comes across without much feeling, since at this stage you know little about the patient and nothing at all about the meaning of the loss. It is far better to offer an empathic response such as "That must have been difficult for you" or "How are you coping?" You can then suggest that this is something you might explore later in the interview. Your response might also depend on how long ago the loss occurred—for an older adult who lost a spouse several years ago, often the most appropriate response is a simple non-verbal acknowledgment such as head nodding with “mm.”

For more detail about the difference between sympathy and empathy, have a look at the short animated video by Dr. Brené Brown. She has done a lot of research in this area and explains how sympathy closes down discussion while empathy opens it up.
https://www.fastcompany.com/3023417/the-power-of-empathy-animated

Empathy is key to building rapport and having an interview that is helpful to the patient while at the same time allowing you to gather accurate clinical information.
Rapport-building techniques can be non-verbal or verbal. Here are some common techniques:

- Practice attentive listening.
- Always maintain an attitude of respect, even with difficult patients or situations.

- Convey appropriate concern with your body language and facial expression.
- Make appropriate eye contact—avoid a fixed gaze, especially with paranoid patients.
- Use language that is non-judgmental.
- Ask open ended questions, e.g. “I’d like to understand more about that…”, “Can you tell me more about…”
- Respond with head nodding (but be sure to avoid the psychiatrists’ occupational hazard of repetitive cervical strain syndrome!) and “mm” responses.
- Practice mirroring—appropriately repeating a few words of the patient’s response (but do not overdo this).
- Make summarizing comments—these are especially valuable and give the patient an opportunity to clarify or correct your understanding.
- Give empathic responses, especially ones that reflect your understanding of the patient’s view of things (standing in their shoes, as it were).
- Put feelings into words.

Another excellent video is the TED talk by Dr. Helen Riess on Dec 12, 2013
(The power of empathy: Helen Riess at TEDxMiddlebury; https://youtu.be/baHrcC8B4WM).
Dr. Riess has a helpful mnemonic to guide your approach:

E – eye contact, eye gaze
M – muscles of facial expression
P – posture, e.g. leaning forward to express concern appropriately
A – affect (identify the expressed emotion of the patient)
T – tone of voice
H – hearing the whole person and understanding the context in which other people live; being curious and non-judgmental
Y – your responses

2. CHIEF COMPLAINT

The approach to this will vary depending on the setting.
In an emergency room: "Tell me what happened that led up to you (coming/being brought) to the hospital.”
In an outpatient clinic: "Tell me what concerns we need to address today.”

Allow the patient to tell their story for at most 3 or 4 minutes. This will give you some sense of what problems to focus on in the HPI. It is also a chance to evaluate their spontaneous speech to assess for thought disorder.

Strategically, this is also an opportunity to build rapport with appropriate empathic comments. At this stage, it is best to offer fairly generic comments about how difficult the situation leading up to the consultation must have been for them.

3. HISTORY OF PRESENT ILLNESS

A. Mood

At the earliest appropriate moment, you need to take control of the interview and proceed with a structured HPI. In most cases this can simply be done by asking directly, "How is your mood?" In other cases, patients may be more difficult to redirect. Sometimes it is necessary to be more specific and suggest, "I would like to be sure I understand how you are feeling about all of this. There are some specific questions I would like to ask. To start with, tell me, how is your mood?"

Tip: if the patient has already told you in the chief complaint that they are struggling with depression, then you can easily move into exploring this in more detail. However, in this scenario, please don't ask "How is your mood?"—it comes across as a bit awkward, since the patient has already described their mood.

Assessment of mood is central to the psychiatric interview and will be essential to arrive at an accurate diagnosis. Mood must be explored in great detail.

There are really only three broad types of mood to consider (this is an oversimplification but covers the majority of psychiatric disorders):

- Depression/mania
- Anxiety
- Fear/anger

Now let's look at each of the three moods in more detail.

i. Depression and Mania

Depression and mania can be considered on a continuum.

Different people will experience depression in different ways. When patients report feeling depressed, you need to ask them, "What does depression feel like to you?" Generally, depression comes in 3 "flavours":

- Predominantly sad (down, blue, tearful)
- Irritable (some manic patients will feel very irritable, but they will also have other symptoms of mania)
- Anhedonic (experiencing a loss of pleasure and enjoyment, often associated with a lack of motivation; severe anhedonia is also called melancholia)

Tip: Avoid exploring the patient's activities and interests at this point in the interview. You will do that later when you ask about behaviour changes. The focus now is on the patient's emotional state.

You also need to know three things about the patient's depression:

- How bad is it?
- Is it there most of the time, most days?
- Does it ever get so bad that you have thoughts that life isn't worth living—thoughts of suicide, plans, intent?

Tip: Exploring depression is no different from taking a medical history for pain, e.g. abdominal pain. Just remember the same mnemonic, "PQRST":

describe the **P**ain (in this case emotional pain)
Quality of the pain ("What is like for you?")
Radiate (doesn't really apply to depression)
Severity
Temporal ("Is there a diurnal pattern? When did it start?")

Avoid asking patients to rate their mood on a scale of 0 to 10. It is much better to use a rating scale such as the PHQ9 to quantify depression severity. It is more important to understand what the patient's perception of severity is, "Is this the worst depression you have ever had?"

Suicidality is explored in detail at this stage:

- Do you think that life is not worth living?
- Have you considered plans? How likely would this plan be to succeed (lethality)?
    - More importantly, does the patient believe the plan has a high likelihood of success? Do they have access to the means (especially firearms)?
- Have you taken any steps toward this plan or made any attempts?
- At this moment, do you feel in danger of carrying out this plan?

In your clinical year, you will need to be familiar with standardized approaches to suicide risk assessment such as “IS PATH WARM” and the ASARI assessment tool. The approach to assessing a suicidal patient is covered in more detail in the “Sensitive Interviewing” course.

Generally, you don't need ask screening questions for mania at this stage because it will be readily apparent from the patient's speech and behaviour. If the patient doesn't appear manic, wait until you are asking about past psychiatric history to ask about any periods when the patient was “the opposite of depressed.”

If the patient is (or is likely to be) in a current manic state, you need to ask about what the feeling is like for them. You will cover other symptoms of mania subsequently by sticking to your structured strategic interview. With manic patients, structure becomes even more important; otherwise you will spend all day listening to the patient jump from topic to topic.

ii. Anxiety

Next, you can ask about anxiety. For a basic interview, focus on three aspects of anxiety:

- Do you think that you worry excessively or needlessly, or do other people tell you that you do?
- Do you have panic attacks? (Most people know what a panic attack is, but sometimes you have to describe the main features.)
- Do you have any OCD symptoms like repetitive cleaning or counting, checking, or arranging things?

You could also consider social anxiety, but this might come up a bit later when we cover behaviour.

iii. Fear and Anger

Finally, you need to consider fear and anger. These are the emotions often experienced by people suffering from psychosis. Usually patients will disclose these feelings when you ask about mood. If you have the impression that fear and anger are significant issues, then you will explore this in more detail when we get to thoughts and behaviour. Your sense of the patient's anger will be important in ensuring that you take appropriate measures for your safety.

If anger occurs predominantly in interpersonal relationships, then consider Borderline Disorder. You will discuss relationships when exploring behaviour. A structured HPI will give you the time to explore personal history in more detail to assess for personality disorder.

B. Thoughts and Behaviour

The second section of the HPI covers thoughts and behaviour. This is an area that is often overlooked or not considered in sufficient depth by many learners. It is a good opportunity to get at the underlying psychological symptoms relevant to the patient's presentation. It also helps to formulate a therapy plan. Consider, for example, cognitive behaviour therapy—this will obviously be informed by your understanding of the patient's thoughts and behaviour.

i. Thoughts

There are three categories of thought content to consider based on your understanding of the patient’s mood:

- Depressed or manic thoughts
- Anxious or worrying thoughts
- Fearful or angry thoughts, including delusions and perceptual abnormalities

Usually you will cover thoughts when you are discussing the patient’s mood.

Depressed or Manic Thoughts

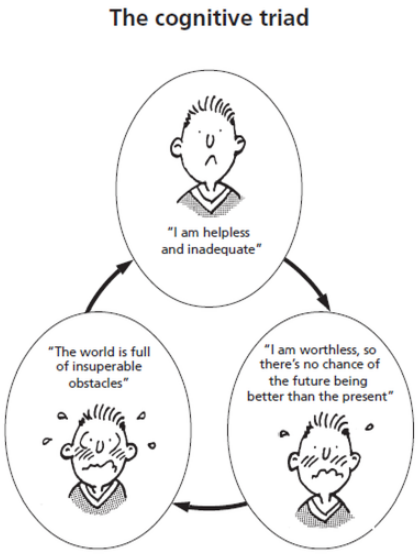
For depression, you need to ask about negative thoughts:

- Worthless thoughts

- Guilty thoughts
- Hopeless thoughts (this links to suicidal thinking)

There may be other negative thoughts that come up during the course of the interview, but these three will cover a lot of ground. This approach is also consistent with a cognitive behaviour therapy approach.

Aaron Beck, the "inventor" of cognitive behaviour therapy, described the cognitive triad - negative view of the self, the world, and the future:



If the patient is manic, then you can ask about:

- Inflated self-esteem—Have you been feeling more self-confident, or feeling that you have special talents or abilities?
- Grandiose thoughts—Any big plans or ideas recently?
- Are your thoughts racing through your mind?

You will ask about behaviour changes next.

Anxious or Worrying Thoughts

You probably already covered worrying thoughts when you were exploring mood. If not, ask, "What worries or concerns do you have these days?" Discuss what situations trigger the anxiety and what thoughts they have. Is the patient aware that their worries are needless or excessive?
This is the start of cognitive behaviour therapy.

Fearful or Angry Thoughts

Generally, there are three situations where you will be exploring fear and anger. You will already have some ideas of what to cover after discussing mood.

The first scenario is screening for psychosis. If you don't think the patient is likely to be psychotic, you still need to ask a screening question: "Have you ever had any experiences recently that were out of touch with reality—maybe hearing sounds or experiencing something strange that other people didn't seem to?"

If the patient is truly psychotic, then you must be more careful.

You will start to suspect the patient is psychotic from their appearance and demeanour. You may have difficulty following what they are saying (thought disorder). The patient may appear tense, distracted, pre-

occupied, or agitated. Context is also important. Acutely psychotic patients are much more likely to be seen in the emergency room setting.

First, ensure that you are safe. If the patient is reacting to your questions with increasing signs of anger and hostility, you likely need to terminate the interview and discuss with your supervisor. If necessary, alert security.

Second, you must ensure that your attitude at all times is extremely serious. It may be helpful to state this to the patient: "It sounds like you have some very serious concerns. I would like to understand more about what is going on for you."

When interviewing a patient with psychosis, we need to consider three main categories:

- Thought process (or thought form)—thought disorder
- Thought content—delusions
- Perceptual abnormalities—hallucinations

(Another situation where anger can also be the predominant emotion is with some personality disorders. Anger will generally come up in their interpersonal relations. It is especially important to consider risk of partner violence and violence toward children or elderly individuals. This is best explored later when asking about the personal history.)

(a) Thought Disorder

Thought disorder may be apparent right from the start of the interview.

The patient's speech may be difficult to follow. If you are confused by what the patient is saying, then consider the possibility of thought disorder. You will need to be aware of the main types of thought disorder (from Andreasen, Nancy 1979):

Poverty of Speech	Restrictions in the amount of spontaneous speech, so that replies to questions tend to be brief, concrete, and unelaborated.
Poverty of Content of Speech	Although replies are long enough so that speech is adequate in amount, it conveys little information. Language tends to be vague, often over-abstract or over-concrete, repetitive, and stereotyped.
Pressure of Speech	An increase in the amount of spontaneous speech as compared with what is considered ordinary or socially customary. The patient talks rapidly and is difficult to interrupt. Some sentences may be left uncompleted because of eagerness to get on to a new idea. Simple questions that could be answered in only a few words or sentences will be answered at great length, so that the answer takes minutes rather than seconds and indeed may not stop at all if the speaker is not interrupted.
Tangentiality	Replying to a question in an oblique, tangential, or even irrelevant manner. The reply may be related to the question in some distant way, or the reply may be unrelated and seem totally irrelevant. The train of thought wanders and never returns to the initial point.
Loose Associations and derailment	A pattern of spontaneous speech in which the ideas slip off the track onto another one that is clearly but obliquely related (loose associations), or onto one that is completely unrelated (derailment). Things may be said in juxtaposition that lack a meaningful relationship, or the patient may shift idiosyncratically from one frame of reference to another. At times, there may be a vague connection between the ideas; at others, none will be apparent.
Word salad – incoherence	A pattern of speech that is essentially incomprehensible at times. The incoherence is due to several different mechanisms, which may sometimes all occur simultaneously. Sometimes the rules of grammar and syntax are ignored, and a series of words or

	phrases seem to be joined together arbitrarily and at random. Sometimes portions of coherent sentences may be observed in the midst of a sentence that is incoherent as a whole. Sometimes the disturbance appears to be at a semantic level, so that words are substituted in a phrase or sentence so that the meaning seems to be distorted or destroyed; the word choice may seem totally random or may appear to have some oblique connection with the context. Sometimes "cementing words" (coordinating and subordinating conjunctions such as "and" and "although" and adjectival pronouns such as "the," "a," and "an") are deleted. Incoherence often is accompanied by derailment. It differs from derailment in that the abnormality occurs at the level of the sentence, within which words or phrases are joined incoherently. The abnormality in derailment involves unclear or confusing connections between larger units, such as sentences or ideas.
Illogical	A pattern of speech in which conclusions are reached that do not follow logically. This may take the form of non-sequiturs (i.e. it does not follow), in which the patient makes a logical inference between two clauses that is unwarranted or illogical. It may take the form of faulty inductive inferences. This particular disorder is also quite common among nonpatients. It may also take the form of reaching conclusions based on faulty premises without any actual delusional thinking.
Neologisms	A neologism is defined as a completely new word or phrase whose derivation cannot be understood. Sometimes the term "neologism" has also been used to mean a word that has been incorrectly built up but with origins that are understandable as due to a misuse of the accepted methods of word formation. The differential diagnosis includes semantic and phonemic paraphasias that can occur in neurologic disorders, for example fronto-temporal dementia (semantic dementia subtype) as well as certain types of strokes.
Circumstantiality	A pattern of speech that is very indirect and delayed in reaching its goal idea. In the process of explaining something, the speaker brings in many tedious details and sometimes makes parenthetical remarks. Circumstantial replies or statements may last for many minutes if the speaker is not interrupted and urged to get to the point. Circumstantiality can become so severe there is loss of goal—failure to follow a chain of thought through to its natural conclusion. This is usually manifested in speech that begins with a particular subject, wanders away from the subject, and never returns to it.
Perseveration	Persistent repetition of words, ideas, or subjects so that, once a patient begins a particular subject or uses a particular word, they continually return to it in the process of speaking.
Echolalia	A pattern of speech in which the patient echoes words or phrases of the interviewer. Typical echolalia tends to be repetitive and persistent. The echo is often uttered with a mocking, mumbling, or staccato intonation. Echolalia is relatively uncommon in adults but more frequent in children.
Thought Blocking	Interruption of a train of speech before a thought or idea has been completed. After a period of silence lasting from a few seconds to minutes, the person indicates that they cannot recall what they had been saying or meant to say. Blocking should only be judged to be present if a person voluntarily describes losing their thought or if, on questioning by the interviewer, they indicate that that was their reason for pausing.
Stilted Speech	Speech that has an excessively stilted or formal quality. It may seem rather quaint or outdated, or it may appear pompous, distant, or overpolite. The stilted quality is usually achieved through use of particular word choices (multisyllabic when monosyllabic alternatives are available and equally appropriate), extremely polite phraseology ("Excuse me, madam, may I request a conference in your office at your

	convenience?"), or stiff and formal syntax ("Whereas the attorney comported himself indecorously, the physician behaved as is customary for a born gentleman.").

Key point: If the patient's speech is not making sense, always consider "organic" causes such as aphasia due to stroke, dementia (especially fronto-temporal dementia), delirium, or intoxication. The context and history will be important in considering the differential diagnosis of abnormal speech.

(b) Delusions

Delusional thinking can sometimes be more challenging, especially if the patient is guarded. If the patient discloses unusual ideas, then explore further using open ended questions and empathic responses. Often it is most helpful to focus on how distressing this must be for the patient and how it is impacting their day-to-day living. By exploring the patient's beliefs in an empathic manner, you should be able to determine whether the criteria for a delusion are met—a fixed, false belief "based on incorrect inferences about external reality despite incontrovertible and obvious proof or evidence to the contrary." No matter how bizarre or implausible the person's beliefs may be, it is important to maintain an attitude of serious concern. For these patients, it is often a matter of life and death to them.

As with many psychiatric symptoms, there is a range or continuum to consider based on how fixed and false the belief is:

Worries and concerns	Preoccupations and ruminations	Overvalued ideas (deeply held convictions that are understandable when the patient's background is known)	Ideas of reference (the belief that events, objects, or other people in the immediate environment have a particular and unusual significance—usually negative)	Delusions (fixed, false beliefs)

Understanding the patient's emotional state associated with the psychosis is also important for diagnosis. The typical delusions to consider with the main psychiatric disorders are as follows:

- Schizophrenia
  - Delusion of control—Who is controlling your mind? Your body? Your feelings?
  - Delusion of reference—What about receiving special messages from people, from the ways things were arranged around you, or from the newspaper, computer, or TV?
  - Persecutory (paranoid) delusions—How are people treating you? Do you feel that people are giving you a hard time or playing dirty tricks on you?
  - Grandiose delusions (also seen in mania)—Do you feel you have any special abilities or talents?
- Major Depression with Psychosis
  - Delusion of guilt—the patient believes they have committed an unforgivable sin or mistake.
  - Persecutory delusions—often in the context of deserved punishment; see above.
  - Delusion of poverty—the patient is convinced that they will become bankrupt and homeless.
  - Nihilistic delusions—usually associated with the belief that there is some awful illness and that they are "rotting from the inside out" (this could be considered a severe form of somatic delusion); in severe cases the patient believes that they are already dead and have ceased to exist.
- Mania
  - Grandiose delusions—the patient believes that they have special abilities or talents, or that they have connections to famous people.
  - Persecutory delusions are also common in mania

Bizarre delusions, which are ideas that are impossible or absurd, can occur in any of the major psychiatric syndromes but are common in schizophrenia. There is an infinite variety of these delusions, so they will generally only come up spontaneously or if you happen to touch on the subject of concern.

(c) Hallucinations

The final area to explore for psychosis is perceptual abnormalities. Again, patients might disclose this spontaneously, but often psychotic patients will be guarded around this.

- Have you ever heard or seen something that other people didn't notice?
- Have you ever heard something unusual and looked around and couldn't find where the sound came from?
- Have you felt anything on your skin or smelled something you couldn't explain?

Always be sure to ask how they felt about the experience.

ii. Behaviour

There are three categories of behaviour to consider:

- Activities and interests
- Social behaviour and relationships
- Function— Activities of Daily Living (ADL): basic ADLs (self-care) and Instrumental ADLs (work, home, academics, managing finances, transportation, managing medications)

Activities and Interests

- What do you usually enjoy doing?
- Have you lost interest in any of your activities and interests?

This is also the best time to ask about concentration, since most hobbies—even just watching television—require some degree of concentration. It may be possible to get a fairly specific measure of concentration by asking how long they can focus on reading. When discussing concentration, you might also remember to ask about ADHD (attention deficit hyperactivity disorder) at this point.

- Have you always had difficulties with concentration?
- Were you ever assessed for ADHD as a child?

If their mood is manic or hypomanic, ask about increased goal-directed activity and risky behaviour:

- Have you been taking on a lot of projects recently?
- Do you find yourself jumping from one task to another before you finish the first one?
- Have you been so active that your friends or family were concerned about you?
- Have you done anything risky or impulsive that could have caused trouble for you or your family?
- Have you been buying things you didn't need?

Social

Ask the patient about their social activities:

- Have you been withdrawing socially, or have you been more outgoing than usual?
- How are your relationships going these days?

Focus on current relationships; you will explore their relationship history in more detail during the personal history.

Function

This is especially important for patients with depression. Are they looking after their basic care and personal grooming, preparing meals and eating properly, managing their medications, and keeping up with household chores? This covers the "basic activities of daily living" as well as some of the "instrumental activities of daily living" (ADLs).

Sometimes patients will be aware that their function is impaired because they are very “slowed down” due to psychomotor retardation. However, this is usually something family or friends will be more aware of. Psychomotor retardation or agitation may also be apparent during the course of the interview.

Functional decline is also a key issue with schizophrenia, but this is best assessed with collateral information from other people who know the patient.

C. Neuro-vegetative: Physical or Somatic Symptoms

Be sure you have thoroughly covered mood, thoughts, and behaviour before moving on to somatic symptoms.

The "classic” neuro-vegetative symptoms commonly associated with psychiatric disorders are concentration, pain, appetite, energy, and sleep:

- Concentration can be affected by many different psychiatric disorders; impaired concentration could be the predominant symptom of ADHD. If you haven’t covered this already when you were asking about their activities and interests, then now would be a good time.
- For some patients, pain may be a significant issue that needs to be explored. Pain and depression are often linked. Pain can also be a significant component of anxiety. Generally, it is better to explore pain issues later in the interview as part of the medical history or review of systems.
- When asking about appetite, it may also be appropriate for some patients to screen for eating disorder. Have they ever had issues with eating disorders such as binge eating or restricting? Also ask about weight change.
- Energy refers to the patient’s physical feeling as opposed to their activity level (which is a behaviour). Do they feel tired and lethargic, or do they have excessive energy? There is overlap with motivation. Some patients describe feeling generally “slowed down” (psychomotor retardation). On the opposite end of the spectrum is psychomotor agitation, which may be observed during the interview and could be related to mania. Some patients describe this as a state of “nervous energy.” If energy and activity are increased, is it goal directed, or are they jumping from one activity to another and not really accomplishing anything (or creating complete chaos!)?
- Sleep should be covered in some detail. What is their usual sleep routine? Do they have trouble falling asleep (initial insomnia), do they wake throughout the night (middle insomnia), or do they wake very early (terminal insomnia)? Consider sleep disorders such as sleep apnea, recurrent nightmares, or restless leg syndrome.

There are other physical or somatic symptom areas that are often relevant to psychiatry, but these are best covered elsewhere in the interview; for example, libido and sexual function can be affected by different psychiatric disorders as well as by medication side effects. It is usually better to explore this later as part of the review of systems.

It is helpful to finish off the HPI by asking about sleep. Many patients will respond that they sleep well (or not) so long as they take their sleeping pills. This makes for a smooth transition to asking about medications.

This is also a good point to pause and summarize. If you are not clear on the time course of symptoms, then you might need to spend a few minutes making sure you are clear about the onset and course of symptoms. In most cases you will already know most of this from exploring the current symptoms.

For the rest of the psychiatric interview it is best to follow a sequence that makes it easier for the patient to understand where you are going. Do not hesitate to provide some guidance or bridging remarks. Just as when you do a physical exam, you should carefully explain what the next step will be. Very few patients are experts at doing psychiatric interviews!

4. MEDICATIONS

Asking about medications following the HPI usually works best, especially if you have finished off with sleep and moved on to discussing sleeping pills. You need to ask if the current medications have been helpful and how long they have been taking them.

Be sure to ask about:

- Side effects, especially sexual side effects
- Allergies
- Natural health products and supplements

5. PAST MEDICAL HISTORY

This will flow easily from the patient's current medications if any of the medications are for medical conditions.

For the psychiatric interview, only cover major illnesses or injuries. If there was a very significant health issue, discuss the impact it had for the patient.

Be sure to ask about any history of head injuries, or seizures.

6. REVIEW OF SYSTEMS

For psychiatric interviews, this is usually fairly brief. If you haven't covered medication side effects, now would be a good time to do so. Neurologic symptoms are important to cover, especially memory problems, impaired balance, tremors, and movement disorder symptoms. This is often the best time to do a cognitive screen such as the mini-mental state exam (MMSE). If the MMSE is more than 24 and you still suspect a memory issue, then do the MOCA (Montreal Cognitive Assessment).

Review of the endocrine symptoms is also important; for example, look for symptoms of hypo- or hyper-thyroidism.

Pain is a very important issue and often has a circular relationship with depression. Ask about appetite and weight change if you didn't cover this during the HPI. Sexual symptoms can be discussed when you are reviewing the genitourinary system.

7. SUBSTANCE USE

This is an essential aspect of the psychiatric history and may require a tactful bridging comment. Many patients may be reluctant to discuss their substance use. They might even feel ashamed of their use. Most people understand the term "substance" as a less pejorative term for recreational or street drug, but you may need to clarify.
"May I ask about your use of alcohol or other substances?"
If the patient uses any illicit drugs, always ask about opioid and intravenous use.

Sometimes a patient might disclose other addictive behaviours at this point, especially if rapport is good, e.g. gambling or sexual addictive behaviours.

8. FORENSIC HISTORY

This should <u>not</u> be routinely explored for second year student interviews. Again, this is an area where tact is especially important.

9. PAST PSYCHIATRIC HISTORY

For most clinical situations, you will be able to get more detail from reviewing past charts than from the patient. Avoid getting bogged down in details trying to pin down dates of repeated admissions during the interview.

Try to get the "broad strokes" of their psychiatric history:

- When did you first seek treatment for a mental health issue?
- Have you been hospitalized? When was the first time? Have there been other admissions?

This may be a good point to ask if they are currently being followed by a psychiatrist or psychotherapist in the community and what programs they are attending. Ask about what therapy or treatments have been particularly helpful in the past.

The psychiatric review of systems can be covered now, especially asking about any history of significant mood swings in the past or previous episodes of psychosis.

10. FAMILY PSYCHIATRIC HISTORY

- Is there any history of mental health issues in your family?
    - If possible, find out if the patient knows what the diagnoses were and whether the family member was hospitalized.
- What about addiction issues?

Covering family psychiatric history now provides a good bridge to the personal history.

11. PERSONAL HISTORY

If all has gone well, you will have spent about 15 minutes on the HPI and 5 to 10 minutes on the past medical/psychiatric history. This will give you 15 minutes to explore the personal history and then arrive at a biopsychosocial formulation.

Start off open ended: "Tell me about your childhood."

We want more detail about infancy and early childhood. The patient will not have any direct memories, but you can often ask what they know about the circumstances of their birth and early development. Ask about what they know about their mother's (or carer's) emotional state and bonding (attachment) when they were an infant.

As you follow the patient's life story, focus especially on relationships. A high percentage of patients referred to psychiatry will have borderline disorder. Look for a pattern of instability in their relationships and in their life in general.

Also, ask about any trauma, abuse, or significant losses. This is usually best done by asking a simple “framing” question: “Trauma and abuse often have serious effects on a person’s physical and emotional health. May I ask if this has been an issue for you?” Intimate partner violence is a significant issue and will be covered in more detail in the “Sensitive Interviewing” course. Beginning interviewers are often understandably uncomfortable dealing with these sensitive issues. At this stage of learning you are not expected to explore these issues in detail, but it is always appropriate to ask, “How are you feeling about this?” and “How are you coping?” Be sure to offer an empathic response.

The personal history should cover the patient’s school years, including academic achievement, friendships, and interests outside of school. This is another opportunity to look for ADHD or other specific learning disability. Also, many psychiatric disorders have their onset in childhood or adolescence. Next, move on to their work or post-secondary academic history. Spend more time on their relationship and marital history,

especially looking for any issues or patterns (for example, repeated brief "unhealthy" relationships). Ask about their children and especially their relationship with grown children.

Finally, finish off with their current situation, and their hopes and plans for the future.

At this point in the interview process, most learners will need to conclude by indicating that they will be discussing the patient with their supervisor before offering any suggestions.

12. MENTAL STATUS EXAM

The mental status exam is carried out continuously over the course of the interview. If at any time you detect that the patient is confused or disoriented, you should as soon as possible establish their orientation and memory function. A delirious or demented patient will require a different approach. In these cases, specific testing such as a Mini Mental Status exam or a Montreal Cognitive Assessment might be appropriate.

You may also have to ask specifically about insight, or the patient's recognition of their symptoms and impairment. Judgment is best assessed by understanding what the patient has actually done in recent situations. This will hopefully be apparent throughout the course of the interview. Often collateral information is required.

The presentation of the mental status exam is organized with the following sections:

1. ***Appearance and general behaviour***
   Provide a description of the patient – their build, grooming, clothing, self-care. This should be a "picture in words" with enough detail that a colleague or supervisor could pick out the patient in a waiting room based on your description. Also describe their level of activity. Do they seem fidgety or pacing? Are they very slowed down? Make note of any tremors or abnormal movements. Also comment on how they interact with you. How is their eye contact? Are they cooperative in providing responses to your questions? Do you think the information they are providing is consistent and reliable? Do you think you have good rapport with the patient?

2. ***Speech***
   Describe the quality of their speech – is their speech fluent? Do they have an accent? Is there a delay before they respond (latency of speech)? Is there poverty of speech or pressured speech?

3. ***Affect and mood, including suicidal ideation***
   Affect is the objective observed description of the patient's emotional state:
   - What is the affect? This is based on the patient's appearance – e.g. downcast, tearful, angry appearing, worried, tense. For beginning interviewers keep in mind the 3 main mood states discussed earlier – depression/mania, anxiety, fear/anger.
   - What is the range of affect – full range vs restricted?
   - Is the affect appropriate to the content being discussed?
   - Is there emotional lability? Do they abruptly become tearful then a moment later start laughing?

   Mood is the patient's own description of their subjective emotional state. Often you can quote the patient's description. Most importantly, describe the patient's suicidal thoughts, plans, or intent.

4. ***Thought process***
   Are the patient's responses logical and concise? Describe any abnormalities such as circumstantial responses, tangentially, and loose associations. Are there any unusual responses such as neologisms or echolalia?

5. ***Thought Content***
   This can range from worries and concerns to themes and preoccupations. Describe any overvalued ideas, ideas of reference, or delusions.

6. ***Perceptual Abnormalities***
   This can be on a continuum:

Alterations in intensity and quality of sensory experiences	Derealization – feeling that that the world is not real, a feeling of estrangement or detachment from one's environment. Depersonalization - feelings of unreality or strangeness concerning the self	Misinterpretations – e.g. mistaking shadows for a person in the room, seeing something unusual or frightening out of the corner of their eye	Visual, auditory, tactile, olfactory hallucinations. Are the hallucinations complex such as voices commenting or giving orders? Or are there just random sounds?

7. ***Cognitive functioning, including memory and higher cognitive functions***
   If the patient is not fully alert, it is best to comment on this at the start of the mental status exam as part of general appearance, since this will impact the interpretation of the rest of the exam.

   In this section you will comment on any indications of memory problems, difficulty with orientation, impaired logic or problem-solving abilities, or impaired comprehension. Report results of formal cognitive testing such as the MMSE or MOCA.

8. ***Insight and judgment***
   Insight is also on a continuum, from no insight to partial insight and full insight. Is the patient aware of having abnormal experiences or feelings? Do they understand that these symptoms are due to a mental illness? Do they believe that they have a mental illness? Do they accept the need for treatment?
   Judgment is a complex consideration that involves taking in information, evaluating it, and arriving at a sensible solution. It is best assessed by understanding the patient's reactions to problems in their life situation. Often this requires collateral information.

13. BIOPSYCHOSOCIAL FORMULATION AND TREATMENT PLAN

Use a 4x3 grid to organize the biopsychosocial formulation: predisposing, precipitating, perpetuating and supportive biological, psychological, and social factors. Go through the above headings in your report to gather data for each of the boxes and decide where the information fits the best. Do not be too concerned if there seems to be some overlap or repetition.

The biopsychosocial model is relevant for all medical and surgical disciplines. It ensures that physicians take a holistic, patient-centred approach.

	Biological	Psychological	Social
Predisposing	• Genetic predispositions/family history • Prenatal/birth: trauma, toxins, prematurity • Developmental disorders • Medical disorders • Neurological disorders: head injury, seizures	• Early attachment (Bowlby) • Early temperament • Good enough mother (Winnicott) • Personality traits • Developmental stage tasks	• HEADS : - Home - Education/Employment - Activities - Drinking/Drugs - Safety/Sex • Socio-economic status • Cultural issues • Spiritual issues • Family/interpersonal issues • Migration
Precipitating	• Relapse of psychiatric illness or substance use • Medical illness/health problems • Medication-related: side effects, drug interactions, non-efficacy, non-adherence	• Trauma, loss, rejection, abandonment • Stress • Significant events activating dynamic issues	• Relationship changes • Family crises • Loss or change of job • Failure or problems at school
Perpetuating	• Chronic conditions: medical, psychiatric, substance use, medications • Disabilities/handicaps	• Poor coping mechanisms and problem solving skills • Pathological defense mechanisms • Negative automatic thoughts and underlying assumptions (CBT)	• Marital discord • Lack of stable housing • Unstable employment and finances • Unemployment • Parental/family conflict
Supportive	• No family history • No medical illness • No substance use • Good adherence to treatment regimen	• Healthy defense mechanisms • Insight/judgment • Intelligence	• Safe housing • Supportive family • Stable employment and finances • Primary relationships are loving, accepting, accommodating • Spiritual support

APPENDIX 1-SAMPLE CASE REPORT

	Comments
Date: April 3, 2017 **Location of Service:** Royal Jubilee Hospital	Start your write up indicating the setting and the supervisor. Then provide a few identifying details so that the reader of the report has some context.
Identifying Data Dawn is a 74-year-old woman who is assessed at Royal Jubilee Hospital. She is a volunteer patient for the first-year medical program clinical skills interviewing course. Dr. Michael Cooper is the supervising psychiatrist. Dawn lives with her second husband in Victoria. She is a retired nurse who last worked in a long-term care facility. The patient has 2 children: a son in Vancouver and a daughter in Ontario.	
CC 1. Chronic recurring Depression 2. Recurring remitting multiple sclerosis	The chief complaint for a psychiatric report can include a medical issue if it is relevant to the psychiatric disorder. As we will see later, multiple sclerosis is relevant for this case report.
HPI Dawn describes a lifelong history of recurrent depression: "a roller coaster of ups and downs." Depressive episodes are characterized by prominent physical pain, decreased energy, profound sadness, and difficulty leaving her home. These episodes can last up to several months, although the severity will fluctuate from day to day. During the "up" periods, Dawn denies any symptoms suggestive of mania or hypomania.	Use the structure of mood, thoughts & behaviour, and somatic (physical) symptoms to organize the report.
The past few weeks have been increasingly difficult due to increased pain due to MS. The cold, rainy weather prevents her from going outside. Currently she finds that she runs out of energy quickly. Dawn describes her current state as "just hanging in." Her thoughts are negative and outlook tends to be "gloomy." Dawn tends to dwell on past mistakes and regrets, often blaming herself and feeling guilty. Self-esteem is also lower. She endorses negative thoughts about the past, present, and future. Dawn denies any suicidal thoughts or intent but often has the thought, "What's the use?"	For patients with depression, you need to comment on guilty thoughts, low self-worth, and future outlook (hopelessness). Suicidal thinking is best included here as well.
Dawn denies excessive or needless worrying. Her concerns about her health seem appropriate. She also denies panic attacks and denies symptoms characteristic of obsessive-compulsive disorder. Dawn denies ever having experiences or feelings that are out of touch with reality. She denies significant issues with anger, although sometimes, when the MS flares up, she gets more irritable and frustrated.	Be sure to comment on the three most common types of mood changes: depression-mania, anxiety, and fear/anger.
Dawn tries to cope with her depression through "over-activity" with crafts, social media such as Facebook, and keeping in touch with various family members. Her activity level has decreased in the past few months. Dawn struggles to keep up with household chores but manages her own self-care adequately. Social activities are limited, especially by pain and fatigue. Appetite is good and there has been no weight change. Patient reports lifelong issues surrounding the ability to stay asleep throughout the night, but this remains unchanging through her depression.	We have some information about her behaviour that fits in nicely with the recommended structure. For physical symptoms, we have already reviewed energy and pain above, which is okay. The other important physical symptoms are concentration and libido (which is best covered with review of systems).

Medications Sertraline 150mg once/day Vitamin D Vitamin B Botox injections (for MS) No use of herbal supplements or natural health products Patient denies any significant side effects from the sertraline. **Allergies** Sulfonamides – anaphylactic reaction	Be sure to insert paragraphs to divide up the HPI. Often the HPI is the longest section and is more readable if there are breaks. Medication side effects should be described either here or in the review of systems.
Past Medical History Scarlet fever, chicken pox, and measles as a child Spinal Stenosis Irritable Bowel Syndrome, Diverticulosis, C. difficile infection Ovarian Cyst Multiple Sclerosis (Remitting/Relapsing) Sleep Apnea (Treats with CPAP) Ovarian cystectomy No history of head injury or seizures **Review of Systems** Cataract in right eye Bilateral hearing aids Ongoing symptoms of irritable bowel managed by diet and laxative Concentration generally decreased Libido and sexual function were not reviewed	For the psychiatric report, we do not need much detail regarding the medical history.
Past Psychiatric History At age 20, patient gave birth to her first child, which subsequently led into a post-partum depression. She spoke of a lengthy "episode" where she stopped eating and sleeping, "zoned out" often, and found it difficult to interact with people. Patient was admitted to the regional psychiatric unit and was treated with sub-coma insulin therapy (SST). She was prescribed amitriptyline for a maintenance antidepressant medication. There is a pattern of depressive episodes that come on during the winter and at the end of summer. The patient attributes the winter depression to not having immediate family in Victoria during the Christmas season. The patient has never thought about, planned, or attempted suicide. There have been no further psychiatric admissions. The patient has been tried on various medications but for many years has been on a consistent dose of sertraline. She has attended previous psychiatrists through her adult life and has now, within the past weeks, met with a psychotherapist, whom she intends to continue working with.	Many patients will have a history of multiple psychiatric hospitalizations and contacts with the mental health system. Provide more detail about the onset of their illness and first contact with mental health system. For multiple presentations, you may only be able to approximately list the locations and number of times the patient was admitted. For a more detailed case review, medical records will be a more reliable source. Be sure to ask about current treatment including psychotherapy.

Substance Use 4 glasses of wine/week Denies use of marijuana or other recreational drugs No previous history of treatment for substance use or dependence	When appropriate, use a screening tool such as CAGE.
Family Psychiatric History Patient's father and his two sisters were diagnosed with depression. Details of their treatment are not known. No major mental illness on her mother's side. Patient's daughter diagnosed with depression and has history of one attempt at suicide. She is now doing well. Details of her treatment and current medication are not known. No other reported family members with psychiatric illness.	Doing the family psychiatric history just before the personal history provides a logical flow to the report. It also is a good way of organizing the interview, since you can bridge smoothly.
Personal History This patient was born in London, Ontario. She is the oldest of 3 children. To the patient's knowledge, there were no complications during pregnancy or childbirth. Dawn was a good student. She was reading and writing at age 5 and skipped Grade 1. The family dynamic was stressed with her father, who was away much of the time working as a travelling sales representative. He also had alcohol dependence issues. His alcoholism remained a secret between Dawn's mother, father and herself—it was kept a secret from the 2 younger siblings. Dawn had to assume responsibilities for looking after her siblings as well as the responsibility of protecting them from the impact of the father's alcohol dependence. Dawn generally had a good relationship with her mother but likely the mother was under a lot of stress, often being the sole parent and having the stress of dealing with her husband when he was around. Dawn was homeschooled for 2 years due to repeated bouts of childhood illnesses until the age of 8. Being away from friends and not having some way of "escaping" the tensions within the home was likely difficult for her, although at that age she did not have an awareness of how it might have been affecting her. In her teen years, Dawn spoke of becoming the troubled child and rebelling against her parents. She left school at age 16 after completing Grade 11, then moved out of her parents' house at age 17. There was a period of impulsive behaviour and unhealthy relationships. At age 20 she moved back into her parents' house with her first child. She then married the father of her children, who subsequently left her for another woman. Patient then moved to Victoria, BC approximately 36 years ago with her second husband. She had infrequent contact with her parents, who are now deceased, and seldom sees her siblings. Dawn completed a nursing degree at age 40 and worked for approximately 15 years before being diagnosed with MS and retiring. Her daily activities have declined over time due to the MS. Dawn is not walking or socializing as much as she would like. Overall, she feels that she is not aging well. On the positive side, Dawn enjoys arts and crafts, painting, sewing, and knitting. Dawn describes her marriage as "not a loving relationship, more of a brother-sister bond," in which they have good conversations but no intimacy. Intimate relationships have always been a complex issue for her, and she feels this might have something to do with her family of origin. For example, she recalls that her parents never were affectionate toward each other. Dawn feels her husband is not very supportive in dealing with her depression.	The personal history should be in a narrative style. Pay particular attention to any details regarding early childhood and family of origin issues. Follow a chronologic order ensuring that key information from childhood, adolescence, and adulthood is included. Most importantly, describe key relationships.

Dawn has good relationships with her children but seldom is able to visit with them. She especially found it difficult when her daughter was struggling with depression. Dawn tends to blame herself for her daughter's predisposition to mental health issues. Also, due to financial and health restraints, Dawn was not able to travel to Ontario to help out, which further exacerbated her guilt.	
Mental Status Examination The patient is a 74-year-old woman who is neatly dressed and groomed. She has shoulder length grey hair. The patient uses a cane and gait appears unsteady, likely due to MS. Eye contact is appropriate.	Start the MSE with a description of the patient. There should be enough detail to be able to pick out the patient in a waiting room.
Rapport was established and the patient was open in talking about her issues and concerns. The patient became visibly distressed when the issue of sexual abuse was discussed and did not wish to discuss this further.	In an ER setting the description is very important. For example, a patient might appear quite different when first brought to the ER and when another psychiatrist assesses the patient the next day. They will need an accurate picture of the initial presentation to compare.
Speech is normal in rate and rhythm and there is no dysarthria apparent. There were occasional pauses in her speech before responding to more difficult issues. The patient is able to sit comfortably for the duration of the interview and there are no tremors or other abnormal movements.	
There is a normal range of affect, and affect was appropriate to the issues being explored. At times the patient tried to make light of distressing situations and used humour as a defense. There were no signs of emotional lability. Subjectively, the patient reported her mood as moderately depressed. She denied any suicidal thoughts or plans but often thinks, "What's the use?" She is especially discouraged at her chronic pain and the disability due to MS.	Suicidal assessment is a repetition from the HPI but it is important to include the presence or absence of suicidal thoughts or plans in the MSE. If the patient endorses thoughts or plans, then also cover intent and protective factors in the MSE.
Thought form is logical and goal directed. There were no abnormalities of thought form.	
Patient had several realistic concerns regarding her health and loss of independence in relation to her ongoing struggle with MS. There is also a tendency to guilty thoughts, especially at times when her depression is more pronounced. There are no delusions apparent. There are no perceptual abnormalities.	
On cognitive assessment, the patient is oriented to time and place. She is able to register and recall three words. On the mini-mental state examination, the patient scores 29/30, making a minor error on design copying.	Cognitive assessment will vary depending on the circumstances. More detailed assessment is required, for example, when the patient appears confused or when co-morbid neurologic disorders are suspected.
The patient demonstrates good insight into the complex underlying issues for her depression. Judgment appears intact based on the patient's report of her day-to-day problem solving and decision making. She is accepting of the need for treatment.	
Diagnostic Classification The working diagnosis based on DSM5 is Persistent Depressive Disorder. The differential diagnosis includes mood disorder secondary to another medical condition (multiple sclerosis). There may also be a seasonal variation of her mood disorder.	
Diagnostic Formulation and Treatment Plan This is not required for this introduction to clinical skills. The case report concludes with a biopsychosocial formulation and treatment plan, including a comment on prognosis.	

APPENDIX 2-BIOPSYCHOLOGICAL FORMULATION GRID

	Biological	Psychological	Social
Predisposing	Genetic predisposition, pregnancy/childbirth complications	Attachment and bonding during infancy, childhood temperament and development.	Socio-economic status, cultural issues and immigration. Family and extended family support.
Precipitating	Relapse of a recurring psychiatric or medical disorder. Medication issues or adherence.	Trauma, Loss, Rejection, Abandonment Stress	Relationship changes Family crises Loss or change of job Failure or problems at school
Perpetuating	Chronic conditions: medical, psychiatric, substance use, medications Disabilities	Poor coping mechanisms and problem-solving skills, Pathological defense mechanisms	Marital discord Lack of stable housing Unstable employment and finances Parental/family conflict
Supportive	No family history, No medical illness, No substance use Good adherence to treatment regimen	Healthy defense mechanisms Good insight/judgment Intelligence	Safe housing, Supportive family Stable employment and finances Primary relationships are loving, accepting, accommodating Spiritual support

APPENDIX 3-EMPATHY CHECKLIST

	Brief examples or descriptions observed during the interview
Non-verbal behaviour—eye contact, posture, facial expression, appropriate head nodding	
Open ended questions	
Mirroring comments	
Summarizing comments	
Empathic comments	
Bridging comments that ensure the patient can follow the structure of the interview	
Framing comments that provide a brief, appropriate explanation for why the question is being asked	
What is your overall impression of the interview? How was rapport (and how did you assess rapport)?	