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# Brief Psychiatric History and Mental Status Examination

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A comprehensive medical evaluation includes a thorough history, physical examination, and appropriate laboratory, imaging and other studies. An important portion of the history in a primary care evaluation is the psychiatric history and the mental status examination. When evaluating a patient for mental or emotional disorders, history is truly everything. Often, the practitioner must ask specific questions to assess the presence of common mental disorders in order to supplement other information or because the patient does not recognize or does not volunteer the symptoms.

Casting ones net for the symptoms of common mental disorders, including the category of anxiety disorders, is extremely helpful to fully assess a patient's emotional and physical status. Disorders that comorbidly occur may further complicate matters, especially if common symptoms are shared. For example, shared symptoms of both generalized anxiety disorder and major depressive disorder include worrying, poor concentration, insomnia, fatigue, irritability, and somatic concerns. An appropriate diagnosis and treatment plan can be instituted only after the clinical symptoms and signs are fully recognized and evaluated.

The information in this book is applicable to evaluations of adult patients, age 18 years or older, although sections may be applicable to younger patients. The information is based on scholarly information supported by research and practical suggestions based on cumulative clinical experiences of the authors.

## EVALUATING ANXIETY DISORDERS

Anxiety disorders are the most prevalent mental disorders in the general population [1]. They are a family of related but distinct disorders. Anxiety disorders are complex disorders and may be difficult to recognize and treat, especially if there are comorbid problems such as depression and substance abuse. There are

no distinctively characteristic markers to make a presumptive diagnosis of an anxiety disorder despite an abundance of physiologic symptoms [1]. Psychophysiology, a noninvasive tool dealing with the correlation of the mind and body, historically has relied on electrical signals generated by the body and recorded by way of electrodes on the scalp, hands, and face. It is used to quantify normal and abnormal physiological activity and reactivity [2]. In addition to measures such as palmar sweating, respiration, heart rate, blood pressure, and reflexes, psychophysiology has incorporated neuroendocrine physiology and brain imaging such as positron emission tomography (PET) [2]. It is interesting to note that despite physiological symptoms playing a crucial role in the diagnostic profile of anxiety disorders, the evaluation of symptoms and the formal diagnosis are based primarily on verbal self-reports. Physiological measures have the potential to help objectively assess and better characterize anxiety symptoms and identify psychological and neurobiological dysfunctions [2]. Psychophysiology essentially remains a research tool, however, regarding the causes and nature of anxiety.

## DIAGNOSIS OF ANXIETY DISORDERS

The diagnosis of anxiety disorders continues to depend on the clinical interview, which utilizes self-reports of symptoms as well as observation of objective signs of anxiety. An index of suspicion is often helpful in assessing the presence of an anxiety disorder. For example, a patient may not present with the classic symptoms such as excessive hand-washing rituals in obsessive-compulsive disorder. Instead, severe obsessive thinking and perhaps checking rituals may be present, and the patient fails to mention these symptoms to the examiner. Clinical experience has shown that several psychiatric disorders, including social anxiety disorder, obsessive-compulsive disorder, posttraumatic stress disorder, as well as bipolar disorder and adult attention-deficit/hyperactivity disorder, commonly occur, may not readily present themselves, and are easily missed. It is interesting to note that three of these five easily unrecognized disorders are categories of anxiety disorders!

The subtypes of the anxiety disorders are defined by the standardized diagnostic criteria of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition, text revision (DSM-IV-TR) [3]. Table 2.1 lists the categories of DSM-IV-TR anxiety disorders [3]. Tables 2.2 through 2.9 list the key features of the common anxiety disorders [1,3]. Although adjustment disorder with anxiety is not a formal anxiety disorder in the DSM-IV-TR, it is an important disorder to recognize

TABLE 2.1. DSM-IV-TR anxiety disorder categories

- Adjustment disorder with anxiety*
- Panic disorder (with/without agoraphobia)
- Phobic disorders
  - Agoraphobia**
  - Specific phobia
  - Social phobia (social anxiety disorder)
- Obsessive-compulsive disorder
- Acute stress disorder
- Posttraumatic stress disorder
- Generalized anxiety disorder
- Anxiety disorder due to a general medical condition
- Substance-induced anxiety disorder
- Anxiety disorder not otherwise specified

*Not a formal DSM-IV-TR anxiety disorder.
**Not a DSM-IV-TR codable disorder.
Adapted from ref. [3].

TABLE 2.2. Key features of panic disorder

- Recurrent unexpected panic attacks
- Persistent concern about additional attacks
- Worry about the meaning of or the consequences of the attacks (e.g., heart attack, stroke, "going crazy")
- Significant change in behavior related to the attacks (e.g., avoiding places)
- With or without presence of agoraphobia

Adapted from refs. [1] and [3].

TABLE 2.3. Key features of agoraphobia

- Anxiety about being in places or situations from which escape might be difficult, embarrassing, or in which help may not be available in the event of having a panic attack
- Places and situations are avoided or endured with anxiety or distress

Adapted from refs. [1] and [3].

TABLE 2.4. Key features of specific phobia

- Marked and persistent fear that is excessive, unreasonable, and brought on by the presence or anticipation of a specific object or situation
- Exposure provokes an immediate anxiety response
- Recognition that the fear is excessive or unreasonable
- Phobic stimulus is avoided or endured with distress
- Avoidance, anticipatory anxiety, or distress is significantly impairing

Adapted from refs. [1] and [3].

TABLE 2.5. Key features of social phobia (social anxiety disorder)

- Marked and persistent fear of one or more social or performance situations in which the person is concerned about negative evaluation or scrutiny by others
- Recognition that the fear is excessive or unreasonable
- Fears acting in a way or showing anxiety symptoms that will be humiliating or embarrassing
- Feared social or performance situations are avoided or endured with intense anxiety or distress

Adapted from refs. [1] and [3].

TABLE 2.6. Key features of obsessive-compulsive disorder

- Experiencing obsessions or compulsions
- Recognition that the obsessions or compulsions are excessive or unreasonable
- Obsessions or compulsions cause much distress, are time-consuming, or cause significant interference in daily functioning

Adapted from refs. [1] and [3].

TABLE 2.7. Key features of acute stress disorder

- Exposure to a traumatic event
- Individual experiences dissociative symptoms
- Traumatic event is persistently reexperienced
- Marked symptoms of anxiety and increased arousal
- Marked avoidance of stimuli that arouse trauma recollection
- Disturbance occurs within 4 weeks of the traumatic event, lasts for a minimum of 2 days and a maximum of 4 weeks
- Disturbance causes significant distress or impairment in daily functioning

Adapted from ref. [3].

TABLE 2.8. Key features of posttraumatic stress disorder

- Exposure to a traumatic event
- Traumatic event is persistently reexperienced
- Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness
- Persistent symptoms of increased arousal
- Duration of the disturbance is more than 1 month
- Disturbance causes significant distress or impairment in daily functioning

Adapted from refs. [1] and [3].

TABLE 2.9. Key features of generalized anxiety disorder

- Excessive anxiety and worry about a number of events or activities for at least 6 months
- Difficulty controlling the worry
- Anxiety and worry associated with additional symptoms, including somatic
- Anxiety, worry, physical symptoms cause significant distress or impairment in daily functioning

Adapted from ref. [3].

and evaluate in primary care. For conditions that approach but do not fulfill diagnostic criteria for a major psychiatric disorder, diagnostic and treatment decisions rely on a practitioner's clinical judgment [4]. This certainly applies to the anxiety disorders as well. Subthreshold conditions are important to recognize and evaluate, especially if they impact personal, social, occupational, and academic functioning. The current diagnostic criteria for many mental disorders include the stipulation that the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. Some clinicians feel that suffering from the diagnostic symptoms may be sufficient for a diagnosis at times, even before functional disturbances appear. Treatment may not be necessary at the time but monitoring may be warranted.

The careful evaluation of the patient by the primary care practitioner regarding anxiety symptoms is important for comprehensive care. The recognition and management of anxiety disorders, either individually or comorbidly, is important for the patient's quality of life. Distinguishing the common anxiety disorders from each other and other psychiatric and general medical disorders can be significant regarding treatment decisions. The practitioner and the patient may never know if an anxiety disorder is present unless specific screening questions are asked about each specific anxiety disorder category. A patient may not volunteer the symptoms of an anxiety disorder initially as the chief complaint or even after a few open-ended questions are asked. Closed-ended questions are often necessary to actively screen for the common anxiety disorders.

## SCREENING FOR ANXIETY DISORDERS

Formal screening guidelines and suggestions for anxiety disorders are practically nonexistent [5]. Representative common anxiety disorder screening questions for the busy practitioner are listed in Tables 2.10 to 2.15 [6,7]. Many questions are adapted from

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