Curation of patients with mental disorders

Scheme for compiling a medical history

1. **Title page layout.**

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2. **Scheme of disease history.**

I. General information about the patient:

1) Name (may be abbreviated to one letter).
2) Birth date, age.
3) Education.
4) Family status.
5) Profession, place of work and position.
6) Date of admission to the hospital.

II. The reason for admission to the hospital (suicidal tendencies/aggressive behavior/food refusal/inadequacy/physical helplessness/forensic or other examination/seizures etc.)

III. Who sent patient to hospital (patient themself, ambulance, district psychiatrist)

IV. Patient's complaints:
1) at the time of curation;
2) at the time of admission to the hospital.

Complaints of the patient should be studied in detail. For example, it is not enough to note that the patient is disturbed by "voices". It is necessary to clarify the nature of the "voices", the time of their appearance, localization, the presence or absence of feeling of "artificiality", etc. When describing complaints, it is necessary to state them, as the patient says, without qualifying them, for example,it should be noted that the patient complains of "female voices sounding in the left side of the head, which orders to…", without using special terminology (i.e. without expressions like "the patient complains about imperative pseudo-hallucinations").

V. Anamnesis:

1) Anamnesis vitae:

The collection of information by age periods of life, starting with family history and the birth of the patient, his early development. Patient should be asked about the character traits of relatives by which he was raised, the incidence of mental illnesses in family (delicately), nervous, somatic disorders, alcoholism, drug and substance addiction, cases of suicide. Find out the state of health, illness, injury of the mother of the patient during pregnancy, was giving birth physiological or there were complications. Find out when patient began to hold his head, sit, stand, walk, talk first words, phrases. Identifiy the features of the child's temperament by playing activities. Describe the development and behavior in kindergarten, at home, relationships with brothers and sisters and other children. Indicate the age of entry to school, if it is delayed, then state the reason. School performance, both general and in specific subjects (exact sciences, humanities), favorite and unloved subjects, whether he duplicated classes and for what reason. Describe educational and labor activity of the child, adolescent, compliance with their age. Indicate the number of completed classes. If the training ended prematurely, specify the reason (material difficulties, learning difficulties). Further education (school, technical school, university). Describes the age of marriage, legally formalized or civil. The main features of the relationship of the patient with the marriage partner, their duration, reasons for breaking up marital relations (physical, material, psychological, cultural, sexual factors). The number of children and the patient's attitude towards them are ascertained. You should ask patient about the period of conscription into the army, demobilization, the reasons for the delay in

conscription and early demobilization, how he endured the hardships of army service, were there promotions or penalties. It is necessary to ask about the success in acquiring a specialty, attitude towards it (beloved, unloved), peculiarities of labor activity throughout life, relations in labor collectives (good, conflict), whether he changed his place of work and the reasons for this. Describe somatic diseases transferred in childhood, adolescence, adult life. Find out the attitude to alcohol, nicotine, drugs. Clarify the frequency, dose, motives of the consumed psychoactive substance, how this consumption was reflected in physical and mental health, whether he was treated by narcologists. Conflict and other psycho-traumatic situations that arose throughout life, the reaction to these situations, the appeal to the help of a neurologist and a psychiatrist.

2) Anamnesis morbi:

The circumstances preceding the first visit to a psychiatrist or the first hospitalization in a psychiatric hospital (mental trauma, concussion, somatic diseases and etc.) should be described. Reveal the initial manifestations of mental disorders and their connection to exogenous factors (or lack it). The further course of mental disorders is presented in a concise form according to the data epicrises, reasons for hospitalization in psychiatric hospitals, indicating the duration of inpatient treatment and periods of stay at home prior to actual hospitalization. At the same time, changes in social patient status (decrease, growth, stability).

3) Somatic state (the conclusion of the therapist from the medical card of patient).
4) Neurological state (the conclusion of the neurologist from the medical card).

VI. Mental status.

This is the most important, central part of the disease history. Questioning is the leading method of psychiatricresearch and it's inseparable from observation. Examinating the patient, we observe him and ask the questions that have arisen in connection with our observations. To diagnose the disease, to establish all its features, it is necessary to carefully monitor the behavior of the patient; expression of his face, intonation of voice, to catch his slightest changes, to note all patient movements. Mental disorders in one form or another, often barely noticeable, affect the appearance patients, in their behavior. For example, the patient denies the presence of voices, but listens to something or sometimes covers his ears with his hands, or begins to speak into empty space, etc.

Writing of the mental status is carried out by sequentially studying the mental spheres of the patient. If at present the patient does not have a violation of any mental sphere, then ask about violations he had before; such anamnestic information should also be described in details, like those that the patient has now. Many years of experience in teaching psychiatry testifies to the greatest expediency of the following scheme for the study of mental status:

1) Consciousness.
2) Perception.
3) Attention.
4) Memory.
5) Thought process.
6) Intellect.
7) Emotions.

8) Motor and volitional sphere.
9) Behavior and drives.
10) Critical attitude.

At the end of each item (mental sphere) assess its condition – is it normal or violated and wich way. For example, "memory within the normal range", "emotions without deviation from the norm."

Consciousness	Its state is assessed by examining the signs of Jaspers (the presence of all of them reflects violation of consciousness).
Perception	Revealing complaints about disorders of sensations, perception, at the present time and upon admission to the hospital (illusions, hallucinations, senestopathy, psychosensory disorders, etc.). States of "deja vu" and "jamais vu" are noted. Sometimes the presence of hallucinations can be judged by behavior of the patient when, for example, he begins to listen to "voices" (at this moment it is better to *ask not if he's hearing any voices*, but *what are the voices telling him now*).
Attention	The patient is asked whether he is attentive or distracted, whether he can work (read) in noisy, cramped environment. In the conversation, stability of attention, focus, concentration, activity, degree of distractibility, switchability is noticed. Describe the identified symptoms (pathological chainedness, exhaustion, absent-mindedness, stiffness of attention).
Memory	We are interested in the patient's state of memory, the predominant type of memory (mechanical memory, semantic, visual, auditory, motor). Collecting an anamnesis from a patient, compare the volume, accuracy, readiness, the speed with which he describes the history of life (long-term memory), the circumstances of the present hospitalization (short-term memory), current events of the day (ability to fix).
Thought process	Human thinking is expressed through speech. Speech, first of all, should be a means of communication and therefore understandable. Speech is described by form: tempo, harmony (are the words connected grammatically, are the judgments logical, do they make sense, whether the conclusions are consistent), purposefulness (substantially whether the questions asked answer the patient, how real his ideas are, what is relevant for the patient, what topic interests him more). Pay attention to formal disorders of thinking, and the corresponding symptoms are named. Then the content is described. Normal speech should reflect real events relevant to the patient, taking into account age and interests. The curator's attention is drawn to unusual, unrealistic judgments and conclusions, or to ideas that the patient is extremely overwhelmed. The attitude of the patient to his statements is noted, as far as he is convinced that he is right, how he substantiates his ideas, whether critical thinking is preserved at the same time.
Intellect	Normally, the level of intelligence depends on age, education received, in what conditions patient was brought up. When assessing the level and development of intelligence, anamnestic

	information should be taken into account: the time when the patient began to hold his head, sit, walk, talk, perform simple self-care activities, did he study during auxiliary school. What was the performance at school, in what subjects did he especially succeed. Intellectual the level of a patient with a higher education often becomes clear after collecting an anamnesis. In his story, the patient uses general and professional concepts, expresses judgments, conclusions. It should be noted how he understands the curator's questions, immediately or after repetition, accurately or inaccurately. Reveal the stock of community knowledge in according to the occupation of the patient, whether he is a rural or urban resident. Determine the level of awareness subject in everyday matters, the ability to solve practical problems. Find out the stock of school and professional knowledge and skills within the scope of the education received, whether the patient is able to clearly explain the professional terminology and what is the essence of his specialty. Clarify the range of his intellectual interests. On the decline of intelligence indicates a significant loss of previously acquired theoretical knowledge and practical skills, which leads to to a decrease in the social and professional level.
Emotions	Some information may be received from the patient's answers to questions about what mood he has now, how it mostly happens lately, how it fluctuates, how long they remember the offense, how they react to it. If patients note a decrease in mood, carefully identify suicidal thoughts. Delicately ask questions: "*Is it possible you are in such a disgusting mood that you don't even want to live?"* or "*Are there any bad thoughts to do something with yourself?"*. When describing the mood, attention is drawn to the general facial expression, posture. Note the prevailing background, stability, causation of a particular mood. Emotional attitude of the patient to various objects of reality (to relatives, friends, colleagues, to work, medical staff, to himself) is found out by asking how he feels about it, and also, observing the facial expression of the patient when he talks on the relevant topics (in this case, the expression is indicated joy, grief, sadness, fear, kindness, anger, etc.). During a clinical study of the emotional sphere of the patient the following symptoms should be identified: hypothymia, depression, hyperthymia, euphoria, weakness of mind, reactive lability, dysphoria, emotional monotony, flatness, apathy, anxiety, etc.
Motor and volitional sphere	In a conversation, the volitional qualities of the patient are revealed. Ask about his perseverance suggestibility, patience. Pay attention to appearance: negligence in hair, clothes, indirectly speak of decrease in initiative. Find out the patient's plans for the future, the correspondence of these plans to real possibilities. Observe the behavior during the conversation (inactivity, fussiness, restlessness, natural posture). It is necessary to reflect both quantitative and qualitative aspects of the patient's psychomotor sphere. Any manifestations of mannerisms (unnaturalness) of movements, their non-purposefulness in the form of twitches, stereotypical movements.

	Note excessive gestures or vice versa - the impoverishment of actions, their rigidity, gait style, coordination of actions.
Behavior and drives	This section of the mental status describes the behavior of the patient during the examination and outside the situation. Note the demeanor in a conversation with students, with the attending physician, medical staff, other patients (manifestations of arrogance, rudeness, flattering politeness, culture). Behavior is observed when you come to department. Pay attention to what the patient is doing (he is alone or talking to someone if he is busy with labor processes - how he does it, willingly or sluggishly), whether he reads books, watches TV. Ask the patient about whether he has ever or recently experienced disturbances of drives (food, sexual, self-preservation), as they manifested themselves. The description of cravings can also be based on the observations of medical staff (e.g. the patient is seen to be constantly eating/ sexually intrusive towards other patients /expressing suicidal thoughts, etc.)
Critical attitude	Ask the patient if he understands the reasons for hospitalization, if he agrees with them. Patients with a neurotic level of disorders often have complete criticism of their illness and seek to get rid of it. Patients with psychotic disorders more often do not realize that they are ill, deny the need to be in the hospital and the need for treatment in general, in which case it is said that there is no criticism. Sometimes the patient may agree with the presence of the disease / the need for treatment and hospitalization, but not realize the essence of his disorder, for example, the patient says that "he is very sick", "he needs medical attention", but at the same time does not understand that hallucinatory images he sees, or, for example, delusional ideas, are unreal - in this case, "formal" criticism is noted. If the patient has disorders of the motor, volitional sphere, behavior and drives, it should also be clarified whether he understands the causes and consequences of these disorders.

The mental status of the patient should be written according to the following scheme: first, descriptions of any symptoms, and then their qualification, definition is given. For example: "the patient hears a woman's voice, commenting on his thoughts, actions, sometimes ordering the patient to perform any actions (verbal commenting and imperative hallucinations)". Or "the patient complains that every time he stays in apartment alone, he feels a strong fear that something will happen to him, his heart will stop, no one can help him, call an ambulance; understands the groundlessness of his fears, but cannot overcome them (obsessive fear - cardiophobia).

Qualification of mental status - the curator must assess the mental status of the patient in the form of a syndrome.

To do this, of all the symptoms identified in the course of the study, it is necessary to determine the one that reflects the greatest depth of damage to the psyche. Then, it is necessary to logically connect it with other symptoms, constituting a single symptom complex. Thus, the leading (core) psychopathological syndrome, which determines the overall clinical picture of this disease and is

the initial prerequisite diagnostics. For example, "considering that the patient has general and mental weakness, imbalanced mental processes, sleep disorders and autonomic disorders - this condition can be interpreted as asthenic syndrome." Or the following example: "Tthe patient has visual pseudo hallucinations. He complains that his wife, who now lives in Kemerovo, has sex with strangers. She deliberately shows him these scenes inside his head to annoy him). Ideatory automatisms (a group of wreckers, with the help of an apparatus, takes away his thoughts from him), delirium of influence (with the help of the latest electronic technicians observe and experiment on him, directing his actions, causing atrophy of the genital organs by passing an electric current through them). This condition should be interpreted as Kandinsky's Clerambault syndrome.

If the patient has a complex syndrome (a combination of several), then each syndrome is described separately, and in conclusion there will be, for example, "astheno-depressive syndrome", "hysterical state in a patient with dementia".