

TRIPS-2

Training for Interactive Psychiatric Screening - 2

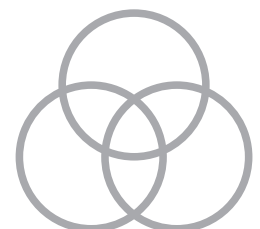
2nd edition, Vienna 2009

An interview for use in non-psychiatric settings
for the quick recognition of

Anxiety Disorders Depression Alcohol Disorders

Heinz Katschnig, MD
Professor of Psychiatry, Medical University of Vienna
Director, Ludwig Boltzmann Institute for Social Psychiatry,
Lazarettgasse 14A-912, A-1090 Vienna, Austria
heinz.katschnig@meduniwien.ac.at
For acknowledgements see back cover

Ludwig Boltzmann Institute for Social Psychiatry, Vienna 2009





What is TRIPS?

Trips is a short tool which assists the general practitioner in carrying out a brief interview in order to diagnose the most common psychological disorders, i.e. anxiety disorders, depression and alcohol disorders. **TRIPS** is constructed in such a way that, after a short training and a few practical applications, the doctor knows how to apply it and does not need the paper version any more.

Why was TRIPS developed?

Up to 30% of patients of general practitioners suffer from one or several of the above mentioned disorders. Rather than going to a psychiatrist, they prefer to see a general practitioner, because there is no stigma attached to such a visit. However, the patients tend to first present physical symptoms, which are often dominant in anxiety disorders (e.g. palpitations), depression (e.g. sleep disorders, loss of appetite) and alcohol disorders (e.g. gastric symptoms, pain in the legs). These physical symptoms often mask the underlying psychological disorder. These disorders are often related to each other, and one can lead to the other (e.g. anxiety and depression to harmful alcohol use, etc.).

In which situation shall TRIPS be used?

In all situations where physical symptoms remain unexplained, or where patients directly complain about psychological distress, **TRIPS** can be applied. **TRIPS** can be used both for patients who come for their first visit and for patients who are already known by the general practitioner. Physical disorders should be ruled out as a cause of the presented symptoms. However, in chronic physical disorders (e.g. diabetes) often secondary psychological disorders develop and **TRIPS** can also be employed with such patients.

Which diagnoses are covered by TRIPS?

TRIPS covers 12 diagnoses contained in Section F of the International Classification of Diseases: 5 anxiety disorders (panic disorder, generalized anxiety disorder, agoraphobia, social phobia, specific phobia), 5 depressive disorders (depressive episode, recurrent depressive disorder, bipolar affective disorder, depressive reaction, dysthymia), and 2 alcohol disorders (harmful alcohol use, alcohol dependence). Since **TRIPS** is a deliberately short tool, it is recommended that the doctor should make himself/herself acquainted with the full description of the diagnoses covered.

What are the limitations of the use of TRIPS?

Other psychiatric disorders than those covered by **TRIPS** (e.g. dementia, schizophrenia) should be ruled out. **TRIPS** is a tool for obtaining descriptive psychiatric diagnoses and does not cover the life circumstances of a patient, which have to be elicited in other ways. In addition to the *informational* aspect covered by **TRIPS**, the *relational* and *emotional* aspect of the doctor-patient interaction is equally relevant. These emotional aspects are not part of **TRIPS**, but must be considered as well. As a rule **TRIPS** should be embedded in a longer interview which takes care of these aspects.



How does TRIPS function?

TRIPS enhances the informational aspect of the diagnostic interview in showing the optimal way of arriving at 12 ICD-10 diagnoses, by providing



- a patient self-rating questionnaire, the results of which show, in which direction the diagnostic interview should go, thus representing a SIGN POST on the road to diagnoses



- three diagnostic decision trees for the three groups of diagnoses covered (anxiety disorders, depression, alcohol problems), each with short definitions of the diagnoses in the respective tree – representing a ROAD MAP for orientation where one could arrive. Before employing **TRIPS** for the first time, the doctor should have acquired full knowledge of these diagnostic trees and the definitions of the disorders contained.



- three interview guidelines for each diagnostic tree, illustrating the optimal route to the diagnoses, representing a COMPASS.

How is **TRIPS** employed in daily practice?

1. As a first step the patient fills in the self-rating screening questionnaire, either in the waiting room or at a separate table. Some patients might need assistance (e.g. because they have forgotten their glasses). The questionnaire starts with physical symptoms, since this increases the acceptance, and continues with anxiety symptoms (red), depressive symptoms (purple) and an alcohol screen (blue).
2. The doctor checks the self-rating questionnaire for symptoms ticked by the patient. For each of the psychological symptom sections of the patient questionnaire where at least one symptom is reported, the doctor proceeds to carrying out the respective interview in this brochure, which has the same colour as the symptom section in the self-rating questionnaire.
3. The doctor documents the diagnoses on the back side of the patients screening questionnaire. The screening questionnaire can be folded and put into the patient file for later reference. Additional information and other diagnostic/therapeutic/referral decisions have to be documented as usual.

If the doctor is not yet used to applying **TRIPS**, he can hold **TRIPS** in his hands while carrying out the interview, make notes, check for formulations, etc. Patients accept this more often than one might think. In carrying out the interview the doctor must keep the balance between asking questions too schematically on the one hand, and “getting lost” in discussions on the other hand. Issues coming up which are not directly related to the questions should be postponed for later discussion. Each module can be finished in between 3 and 5 minutes, depending on how many disorders the patient has and if the “go to” instructions are followed.

What do the abbreviations and the layout of **TRIPS** mean?

Anxiety module: colour is red, symptoms are characterized by **AN 1**, **AN 2**, etc.

Depression module: colour is purple, symptoms are characterized by **DE 1**, **DE 2**, etc.

Alcohol module; colour is blue, symptoms are characterized by **AL 1**, **AL 2**, etc.

YES answers are located in the darker left column, NO answers in the lighter right column

YES

NO

In these columns also diagnoses and “go to” instructions (with an arrow) are included

Social Phobia
F40.1¹

→ AN 10

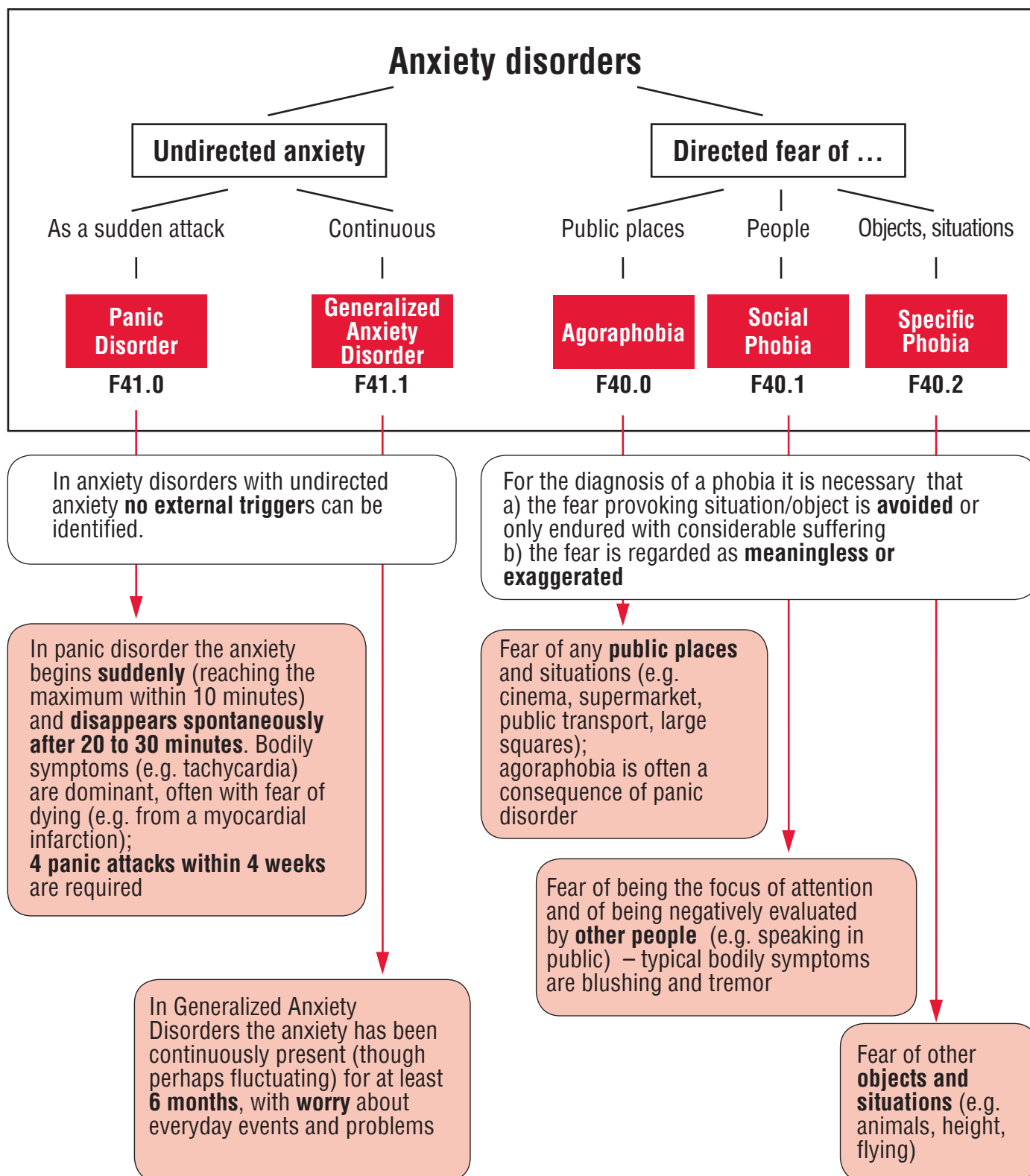
Instructions for the doctor are printed in italics

Examples of direct questions to the patient are printed in bold

Symptoms are printed regularly



Classification of depressive disorders (Selection from ICD-10)



Attention: It is typical for anxiety disorders that they occur together with each other and also conjointly with depressive disorders and alcohol disorders (“co-morbidity”)



ANXIETY (AN) – INTERVIEW PAGE I



All anxiety disorders defined in ICD-10 present with physical symptoms in addition to psychological symptoms. Without such physical symptoms, psychological anxiety, i.e. the feeling of an impending threat, is irrelevant for the diagnosis of anxiety disorders. Therefore, the first step in this interview consists in finding out whether during the preceding 4 weeks a feeling of anxiety was present in conjunction with physical symptoms as described in the list below. Physical disorders must be excluded as cause for these symptoms.

| AN 1 For the last 4 weeks have you been bothered by a feelings of anxiety accompanied by | | YES | NO |
|--|---|--|--------|
| A. Autonomic symptoms | | | |
| A1 | Palpitations, pounding heart? | YES | NO |
| A2 | Sweating? | YES | NO |
| A3 | Dry mouth? | YES | NO |
| A4 | Trembling or shaking? | YES | NO |
| Number of symptoms A | | | |
| At least 1 YES? | | → B | EXIT |
| B. Other anxiety symptoms | | | |
| B1 | Difficulty in breathing? | YES | NO |
| B2 | Feeling of choking? | YES | NO |
| B3 | Chest pain or discomfort? | YES | NO |
| B4 | Nausea or abdominal distress? | YES | NO |
| B5 | Dizziness? | YES | NO |
| B6 | Feelings of unreality ("derealisation", "depersonalization") ? | YES | NO |
| B7 | Fear of losing control, of becoming "crazy"? | YES | NO |
| B8 | Fear of dying? | YES | NO |
| B9 | Chills or hot flushes? | YES | NO |
| B7 | Numbness or tingling sensations? | YES | NO |
| Number of symptoms B | | | |
| AN 2 At least 1 symptom of A and at least 4 symptoms altogether (of A and B)? | | → AN 3 | → AN 4 |
| The following question is intended to diagnose panic disorder | | | |
| AN 3 In the last 4 weeks, have you had at least 4 anxiety attacks i.e. anxiety states that have arisen suddenly with no obvious reason and have disappeared spontaneously after 20 – 30 minutes | | Panic disorder F41.0 ¹ → AN 5 | → AN 5 |
| AN 4 At least 1 symptom of A and 2 or 3 symptoms altogether (of A and B) | | → AN 5 | EXIT |

¹Attention: If in addition to panic disorder also agoraphobia is present, the ICD-10 uses the Code **40.01** ("Agoraphobia with Panic Disorder")



ANXIETY (AN) – INTERVIEW PAGE II

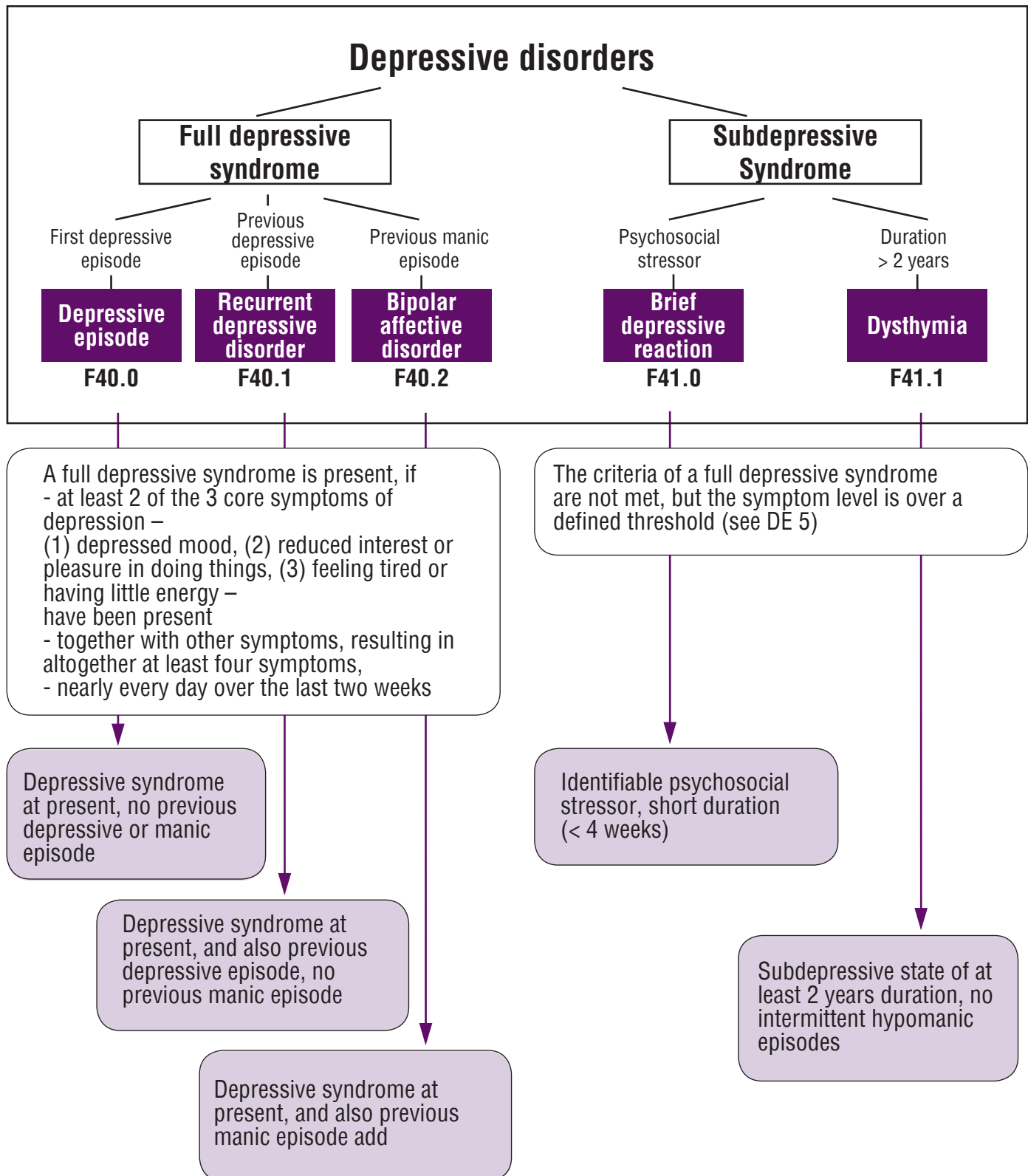


| | YES | NO |
|--|--|---------|
| AN 5 Do you have anxiety states in specific situations (for example in crowded places, public transport, animals, speaking in the presence of other people). Give me an example. | → AN 6 | → AN 12 |
| <p><i>Questions AN 5 to AN 11 are intended to diagnose a phobia. A phobia according to ICD-10 can only be diagnosed, if the two following questions (AN A and AN B) are answered positively. They must be asked if the patient answers positively to AN 6, AN 8, AN 10.</i></p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> AN A Do you avoid these situations or, if you cannot avoid them, do you endure them only with considerable suffering </div> <div style="width: 45%;"> AN B Do you regard this fear as meaningless or exaggerated? </div> </div> | | |
| AN 6 Do you suffer from anxiety states when you <ul style="list-style-type: none"> - are in a crowded place (cinema, supermarket, etc.)? - are in public places (streets, squares)? - travel alone on bus, train, metro? - travel away from home? <p style="text-align: right;">Two or more of the above?</p> | → AN 7 | → AN 8 |
| AN 7 Are AN A and AN B answered positively? | Agoraphobia F40.00 ¹ → AN 8 | → AN 8 |
| AN 8 Do you have anxiety states when you fear being the focus of attention from other people (e.g. talking in front of other peoples, contacting other people)? | → AN 9 | → AN 10 |
| AN 9 Are AN A and AN B answered positively? | Social Phobia F40.1 → AN 10 | → AN 10 |
| AN 10 Do you have anxiety states in other specif situations (heights, thunder, flying, darkness, dentist, animals) | → AN 11 | → AN 12 |
| AN 11 Are AN A and AN B answered positively? | Specific Phobia F40.2 → AN 12 | → AN 12 |
| <p><i>The following questions is intend to diagnose Generalized Anxiety Disorder.</i></p> AN 12 During the last 6 months or more have you been bothered by feelings of pronounced tension, apprehension or worry (e.g. that something might happen to a family member) with anxiety or tension symptoms? | Generalized Anxiety Disorder F41.1 EXIT | EXIT |

¹Attention: If in addition to agoraphobia also panic disorder is present, the ICD-10 uses the Code **40.01** ("Agoraphobia with Panic Disorder")



Classification of depressive disorders (Selection from ICD-10)



Attention! The diagnoses in this module are mutually exclusive. However, co-morbidity of depressive disorders with anxiety and alcohol problems is frequent.



DEPRESSION (DE) – INTERVIEW PAGE I



For any of the 5 ICD-10 diagnoses of TRIPS it is necessary to establish at first whether a “full depressive syndrome” or only a “subdepressive syndrome” is present. For this purpose it has to be checked whether the following symptoms have been present over the preceding two weeks nearly every day.

For a “full depressive syndrome” at least two of the symptoms of group A are required and at least a total of 4 symptoms (of A and B).

For a “subdepressive syndrome” at least the symptom depressed mood (A 1) is required and at least a total of 5 symptoms (of A and B).

| | | | |
|---|--|----------------------------|-----------|
| DE 1 | Which of the following did you experience nearly every day during the last two weeks? | YES “full” “sub” | NO |
| A. Core symptoms of depression | | | |
| A1 | Feeling down, sad, depressed most of the day (different quality than grief!) | YES | NO |
| A2 | Loss of interest or pleasure in activities that are normally pleasurable | YES | NO |
| A3 | Feeling tired or having little energy | YES | NO |
| Number of symptoms A | | | |
| At least A1 (depressed mood) | | → B | EXIT |
| B. Other depressive symptoms | | | |
| (a) Symptoms occurring both in depression and dysthymia | | | |
| B1 | Loss of self-esteem or self-confidence | YES | NO |
| B2 | Trouble concentrating on things such as reading the newspaper or watching television, indecisiveness (reported by the patient or observed) | YES | NO |
| B3 | Sleep disturbances | YES | NO |
| (b) Symptoms specific for depression | | | |
| B4 | Unreasonable feelings of self-reproach or excessive and inappropriate guilt | YES | NO |
| B5 | Recurrent thoughts of death or suicide, or any suicidal behaviour | YES | NO |
| B6 | Being fidgety or restless – or moving or speaking slowly (reported by the patient or observed) | YES | NO |
| B7 | Change in appetite (decrease or increase) with corresponding weight change | YES | NO |
| (c) Symptoms specific for dysthymia | | | |
| B8 | Often in tears | YES | NO |
| B9 | Pessimistic about the future | YES | NO |
| B10 | Social withdrawal | YES | NO |
| B11 | Less talkative than normal | YES | NO |
| Number of YES LEFT: in B (a) and (b) RIGHT: B (a) and (c) | | | |
| DE 2 | At least 2 symptoms of group A and at least 4 symptoms altogether (A and B (a) and B(b)) | | |
| Degree of severity (Number of symptoms) 4-5 mild, 6-7 medium, 8+ (including all 3 of A) - severe | | Full depressive syndrome | → DE 5 |
| | | → DE 3 | |





DEPRESSION (DE) – INTERVIEW PAGE II



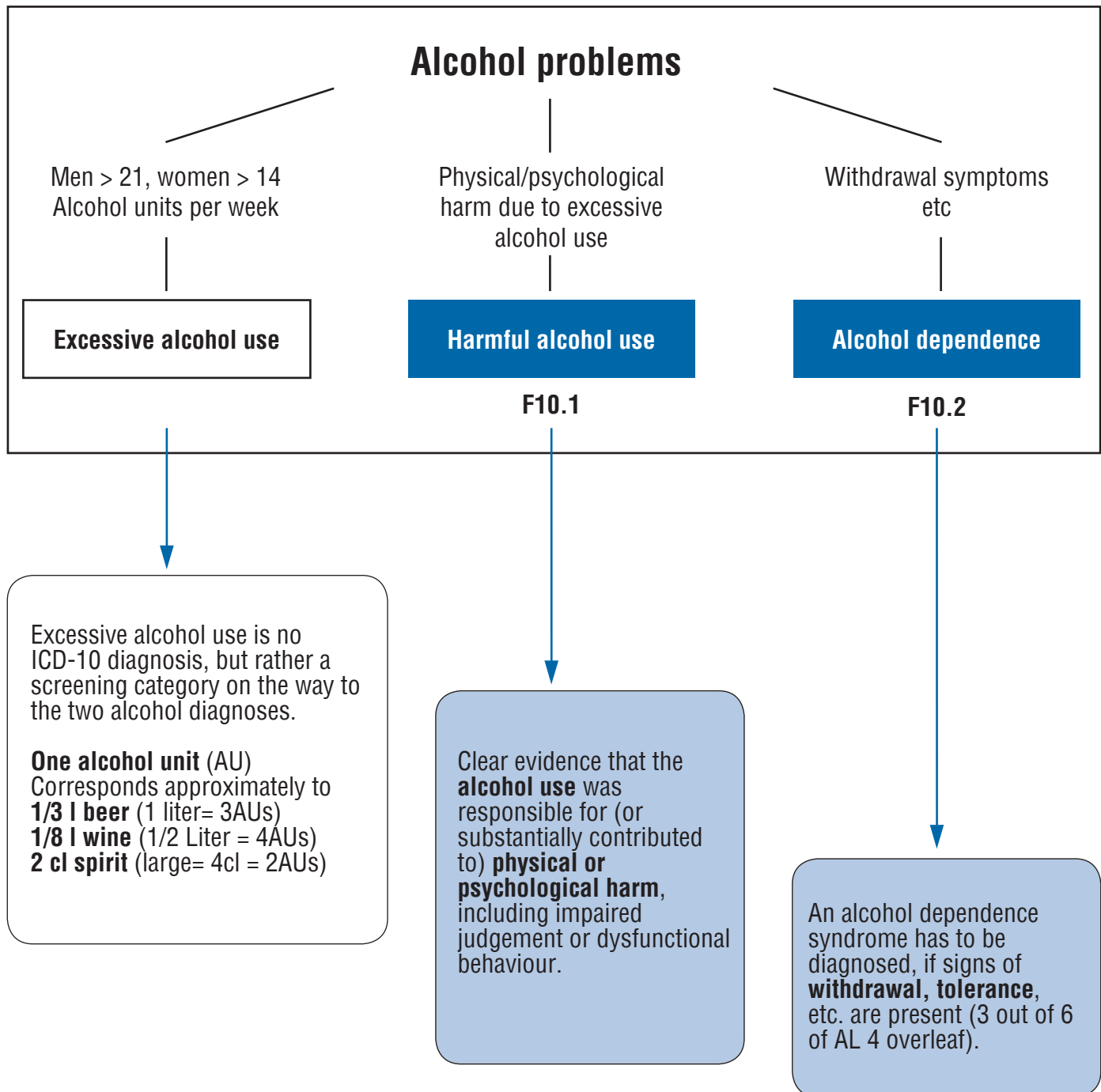
| | YES | NO |
|--|--|---------------------------------------|
| DE 3 Find out whether the patient suffered from a manic or hypomanic episode in the past <i>If unclear: Did you ever experience episodes of elevated mood, extremely increased energy and activity, decreased need for sleep, increased self-esteem? Did this condition last longer than one week?</i> | Bipolar affective disorder F31 EXIT | → DE 4 |
| DE 4 Find out whether the patient suffered from a depressive episode in the past <i>If unclear: Did you ever experience a similar depressive episode as the present one, which lasted longer than 2 weeks?</i> <i>Criterion DE 2 must have been fulfilled – please verify that this was the case.</i> | Recurrent depressive disorder F33 EXIT | Depressive episode F32 EXIT |
| DE 5 A1 Depressed mood is present, together with 4 other symptoms of A, B(a) and B(c) – see previous page | Subdepressive syndrome → DE 6 | EXIT |
| DE 6 This subdepressive syndrome has lasted for more than two years and was not interrupted by hypomanic episodes <i>If unclear: Over the last two years have you felt depressed most of the time, suffered from lack of energy, sleep disturbances without this state alternating with episodes of elevated mood?</i> | Dysthymia*) F34.1 EXIT | → DE 7 |
| DE 7 This subdepressive syndrome has lasted less than 4 weeks and has started after an identifiable psychosocial stressor. Please ask for the presence of a stressor in your own words. | Depressive Reaction F43.20 EXIT | EXIT |



*) Attention: If hypomanic episodes have been present, ICD-10 suggest the diagnosis of “Cyclothymia” (F34.0).
If no hypomanic episodes have been present but the duration has been less than 2 years. ICD-10 suggests the diagnosis of “Other persistent mood disorder” (F 34.8)



Classification of alcohol problems (Selection from ICD-10)



Attention: The diagnoses in the alcohol module of TRIPS are mutually exclusive – there is no comorbidity between them. However, comorbidity with anxiety disorders and/or depression is quite frequent.





ALCOHOL (AL) – INTERVIEW



| | YES | NO |
|---|-------------------------------------|--------|
| AL 1 Find out how many alcohol units (AU) the patient is drinking per week (1 AU = 1/3 l beer, 1/8 l wine, 2 cl spirit) Men: "YES", if more than 21 AUs Women: "YES", if more than 14 AUs | Excessive alcohol use → AL 2 | EXIT |
| AL 2 Physical harm due to alcohol use (gastritis, liver problems, pancreatitis, polyneuropathy) | Harmful alcohol use F10.1 → AL 4 | → AL 3 |
| AL 3 Psychological harm due to alcohol use (impaired judgement, dysfunctional behaviour, memory problems) | Harmful alcohol use F10.1 → AL 3 | → AL 4 |
| AL 4 For the diagnosis of alcohol dependence find out whether at least 3 of the following 6 have been present during the last month / if not during the last month then several times during the last year | | |
| (1) Is the desire to drink irresistible? | YES | NO |
| (2) Is it difficult for you to control how much you drink, to reduce or to terminate your alcohol use? | YES | NO |
| (3) Do you have withdrawal symptoms (e.g. sweating, trembling) if you have nothing to drink, or do you drink to avoid these symptoms? | YES | NO |
| (4) Do you have to drink more to obtain the same effect as usual? | YES | NO |
| (5) Does your drinking take priority to almost everything else? | YES | NO |
| (6) Find out whether the drinking persists in spite of awareness of harmful effect | YES | NO |
| AL 5 At least 3 of the 6 above have been present during the last month / if not during the last month, then several times during the last year | Alcohol dependence F10.2*) EXIT | EXIT |

Acknowledgements

TRIPS-2 is based on the first edition of TRIPS by Heinz Katschnig and Franz Gföllner, Vienna 1999 (supported by Pfizer Austria), which had been based on PRIME-MD, developed by Robert L. Spitzer et al for DSM-IV (Spitzer RL, Williams JB, Kroenke K, Linzer M, deGruy FV 3rd, Hahn SR, Brody D, Johnson JG (1994) Utility of a new procedure for diagnosing mental disorders in primary care. The PRIME-MD 1000 study. JAMA 272: 1749–1756, supported by Pfizer International), and the adaptation by Axel Bertelson for ICD-10. In contrast to PRIME-MD, TRIPS (a) provides ICD-10 instead of DSM-IV diagnoses, (b) focuses on the three most frequent mental disorders in non-psychiatric medical settings in order to save time, (c) has a graphical layout which makes its use easy, and d) has as its main purpose to be a teaching tool for the best and shortest way to arrive at the mentioned diagnoses for non-psychiatric physicians. These design issues of TRIPS have been shown to be useful under the time constraints in general practice settings, with - depending on the numbers of diagnoses – the time needed by a trained physician being between 4 and 10 minutes.



PROGRAMME FINANCED BY THE
EUROPEAN UNION UNDER PHARE