

Psychiatric History and Mental Status Examination

Psychiatric History

The psychiatric history is the record of the patient's life; it allows a psychiatrist to understand who the patient is, where the patient has come from, and where the patient is likely to go in the future. The history is the patient's life story told to the psychiatrist in the patient's own words from his or her own point of view. Many times, the history also includes information about the patient obtained from other sources, such as a parent or spouse. Obtaining a comprehensive history from a patient and, if necessary, from informed sources is essential to making a correct diagnosis and formulating a specific and effective treatment plan. A psychiatric history differs slightly from histories taken in medicine or surgery. In addition to gathering the concrete and factual data related to the chronology of symptom formation and to the psychiatric and medical history, a psychiatrist strives to derive from the history the elusive picture of a patient's individual personality characteristics, including both strengths and weaknesses. The psychiatric history provides insight into the nature of relationships with those closest to the patient and includes all the important persons in his or her life. Usually, a reasonably comprehensive picture can be elicited of the patient's development from the earliest formative years until the present.

The most important technique for obtaining a psychiatric history is to allow patients to tell their stories in their own words in the order that they consider most important. As patients relate their stories, skillful interviewers recognize the points at which they can introduce relevant questions about the areas described in the outline of the history and mental status examination.

The structure of the history and mental status examination presented in this section is not intended to be a rigid plan for interviewing a patient; it is meant to be a guide in organizing the patient's history prior to its being written. A standard format for a psychiatric history is presented in Table 7.1-1. Each topic is discussed below.

Identifying Data

The identifying data provide a succinct demographic summary of the patient by name, age, marital status, sex, occupation, language (if other than English), ethnic background, and religion, insofar as they are pertinent, and the patient's current living circumstances. The information can also include the place or situation in which the current interview took place, the source(s) of the information, the reliability of the source(s), and whether the current disorder is the first episode for the patient. The psychiatrist should indicate whether the patient came in on his or her own, was referred by someone else, or was brought in by someone else. The identifying data are meant to provide a thumbnail sketch of potentially important patient characteristics that may affect diagnosis, prognosis, treatment, and compliance. An example of the written report of the identifying data follows:

Mr. John Jones is a 25-year-old single, white, Protestant male who works as a department store clerk. He is a college graduate living with his parents. He was referred by his internist for psychiatric evaluation.

Chief Complaint

The chief complaint, in the patient's own words, states why he or she has come or been brought in for help. It should be recorded even if the patient is unable to speak, and the patient's explanation, regardless of how bizarre or irrelevant it is, should be recorded verbatim in the section on the chief complaint. The other individuals present as sources of information can then give their versions of the presenting events in the section on the history of the present illness.

If the patient is comatose or mute that should be noted in the chief complaint as such. Examples of chief complaints follow:

- , I am having thoughts of wanting to harm myself. ,
- , People are trying to drive me insane. ,
- , I feel I am going mad. ,
- , I am angry all the time. ,

History of Present Illness

The history of present illness provides a comprehensive and chronological picture of the events leading up to the current moment in the patient's life. This part of the psychiatric history is probably the most helpful in making a diagnosis: When was the onset of the current episode, and what were the immediate precipitating events or triggers? An understanding of the history of the present illness helps answer the question, Why now? Why did the patient come to the doctor at this time? What were the patient's life circumstances at the onset of the symptoms or behavioral changes, and how did they affect the patient so that the presenting disorder became manifest? Knowing the previously well patient's personality also helps give perspective on the currently ill patient.

Table 7.1-1 Outline of Psychiatric History

- I. Identifying data
- II. Chief complaint
- III. History of present illness
 - A. Onset
 - B. Precipitating factors
- IV. Past illnesses
 - A. Psychiatric
 - B. Medical
 - C. Alcohol and other substance history
- V. Family history
- VI. Personal history (anamnesis)
 - A. Prenatal and perinatal
 - B. Early childhood (Birth through age 3)
 - C. Middle childhood (ages 3 ,“11)
 - D. Late childhood (puberty through adolescence)
 - E. Adulthood
 - 1. Occupational history
 - 2. Marital and relationship history
 - 3. Military history
 - 4. Educational history
 - 5. Religion
 - 6. Social activity
 - 7. Current living situation
 - 8. Legal history
 - F. Sexual history
 - G. Fantasies and dreams
 - H. Values

The evolution of the patient's symptoms should be determined and summarized in an organized and systematic way. Symptoms not present should also be delineated. The more detailed the history of the present illness, the more likely the clinician is to make an accurate diagnosis. What past precipitating events were part of the chain leading up to the immediate events? In what ways has the patient's illness affected his or her life activities (e.g., work, important relationships)? What is the nature of the dysfunction (e.g., details about changes in such factors as personality, memory, speech)? Are there psychophysiological symptoms? If so, they should be described in terms of location, intensity, and fluctuation. Any relation between physical and psychological symptoms should be noted. A description of the patient's current anxieties, whether they are generalized and nonspecific (free floating) or are specifically related to particular situations, is helpful. How does the patient handle these anxieties?

Frequently, a relatively open-ended question such as , ,How did this all begin? , leads to an adequate unfolding of the history of the present illness. A well-organized patient is generally able to present a chronological account of the history, but a disorganized patient is difficult to interview, as the chronology of events is confused. In such cases, contacting other informants, such as family members and friends, can be a valuable aid in clarifying the patient's story.

Past Illnesses

The past illnesses section of the psychiatric history is a transition between the story of the present illness and the patient's personal history (also called the anamnesis). Past episodes of both psychiatric and medical illnesses are described. Ideally, a detailed account of the patient's preexisting and underlying psychological and biological substrates is given at this point, and important clues to, and evidence of, vulnerable areas in the patient's functioning are provided. The patient's symptoms, extent of incapacity, type of treatment received, names of hospitals, length of each illness, effects of previous treatments, and degree of compliance should all be explored and recorded chronologically. Particular attention should be paid to the first episodes that signaled the onset of illness, because first episodes can often provide crucial data about precipitating events, diagnostic possibilities, and coping capabilities. With regard to medical history, the psychiatrist should obtain a medical review of symptoms and note any major medical or surgical illnesses and major traumas, particularly those requiring hospitalization. Episodes of craniocerebral trauma, neurological illness, tumors, and seizure disorders are especially relevant to psychiatric histories, as is a history of testing positive for the human immunodeficiency virus (HIV) or having acquired immune deficiency syndrome (AIDS). Specific questions need to be asked about the presence of a seizure disorder, episodes of loss of consciousness, changes in usual headache patterns, changes in vision, and episodes of confusion and disorientation. A history of infection with syphilis is critical and relevant.

Causes, complications, and treatment of any illness and the effects of the illness on the patient should be noted. Specific questions about psychosomatic disorders should be asked and the answers noted. Included in this category are hay fever, rheumatoid arthritis, ulcerative colitis, asthma, hyperthyroidism, gastrointestinal upsets, recurrent colds, and skin conditions. All patients must be asked about alcohol and other substances used, including details about the quantity and frequency of use. It is often advisable to frame questions in the form of an assumption of use, such as , ,How much alcohol would you say you drink in a day? , rather than , ,Do you drink? , The latter question may put the patient on the defensive, concerned about what the physician will think if the answer is yes. If the physician assumes that drinking is a fact, the patient is likely to feel comfortable admitting use. The importance of a thorough, accurate medical history cannot be overstated. Many medical conditions and their treatments cause psychiatric symptoms that without an attentive medical history may be mistaken for a primary psychiatric disorder. Endocrinopathies such as hypothyroidism or Addison's disease may manifest with depression. Treatment with corticosteroids can precipitate manic and psychotic symptoms. In addition, the coexistence of physical disease may result in secondary psychiatric symptoms. A middle-aged man in the aftermath of a heart attack may suffer from anxiety and depression. A patient's medical status will also guide psychiatric treatment decisions. A depressed patient with cardiac conduction abnormalities will not be treated (at least initially) with a tricyclic antidepressant. A bipolar disorder patient with kidney disease will receive an anticonvulsant mood stabilizer rather than lithium. The names and dosing schedules for all currently prescribed nonpsychiatric drugs should be obtained to avoid adverse interactions with prescribed psychiatric medication.

Family History

A brief statement about any psychiatric illness, hospitalization, and treatment of the patient's immediate family members should be placed in the family history part of the report. Does the family have a history of alcohol and other substance abuse or of antisocial behavior? In addition, the family history should provide a description of the personalities and intelligence of the various persons living in the

patient's home from childhood to the present as well as a description of the various households in which the patient lived. The psychiatrist should also define the role each person played in the patient's upbringing and this person's current relationship with the patient. What were and are the family ethnic, national, and religious traditions? Informants other than the patient may be available to contribute to the family history, and the source should be cited in the written record. Various members of the family often give different descriptions of the same persons and events. The psychiatrist should determine the family's attitude toward, and insight into, the patient's illness. Does the patient feel that the family members are supportive, indifferent, or destructive? What is the role of illness in the family? Other questions that provide useful information in this section include the following: What is the patient's attitude toward his or her parents and siblings? The psychiatrist should ask the patient to describe each family member. Who is mentioned first? Who is left out? What does each parent do for a living? What do the siblings do? How do the siblings' occupations compare with the patient's work, and how does the patient feel about it? Who does the patient feel most similar to in the family and why?

Personal History (Anamnesis)

In addition to studying the patient's present illness and current life situation, the psychiatrist needs a thorough understanding of the patient's past and its relation to the present emotional problem. The anamnesis, or personal history, is usually divided into perinatal, early childhood, late childhood, and adulthood (Table 7.1-2). The predominant emotions associated with the different life periods (e.g., painful, stressful, conflictual) should be noted. Depending on time and situation, the psychiatrist may go into detail with regard to each of the following.

Perinatal History

The psychiatrist considers the home situation into which the patient was born and whether the patient was planned and wanted. Were there any problems with the mother's pregnancy and delivery? What was the mother's emotional and physical state at the time of the patient's birth? Were there any maternal health problems during pregnancy? Was the mother abusing alcohol or other substances during her pregnancy?

Early Childhood (Birth through Age 3 Years)

The early childhood period consists of the first 3 years of the patient's life. The quality of the mother-child interaction during feeding and toilet training is important. Frequently, one can learn whether the child presented problems in these areas. Early disturbances in sleep patterns, including episodes of head banging and body rocking, provide clues about possible maternal deprivation or developmental disability. In addition, the psychiatrist should obtain a history of human constancy and attachments during the first 3 years. Were any psychiatric or medical illnesses present in the parents that may have interfered with parent-child interactions? Did persons other than the mother care for the patient? Did the patient exhibit problems at an early period such as severe stranger anxiety or separation anxiety? Explore the patient's siblings and the details of his or her relationship with them. The emerging personality of the child is a topic of crucial importance. Was the child shy, restless, overactive, withdrawn, studious, outgoing, timid, athletic, friendly? Seek data about the child's ability to concentrate, to tolerate frustration, and to postpone gratification. Also note the child's preference for active or passive roles in physical play. What were the child's favorite games or toys? Did the child prefer to play alone, with others, or not at all? What is the patient's earliest memory? Were there any recurrent dreams or fantasies during this period? A summary of the important areas to be covered follows.

Table 7.1-2 Outline of a Developmental History

A. Prenatal and perinatal

1. Full-term pregnancy or premature
2. Vaginal delivery or caesarian
3. Drugs taken by mother during pregnancy (prescription and recreational)
4. Birth complications

5. Defects at birth
- B. Infancy and early childhood
 1. Infant ,“mother relationship
 2. Problems with feeding and sleep
 3. Significant milestones
 - a. Standing/walking
 - b. First words/two-word sentences
 - c. Bowel and bladder control
 4. Other caregivers
 5. Unusual behaviors (e.g., head-banging)
- C. Middle childhood
 1. Preschool and school experiences
 2. Separations from caregivers
 3. Friendships/play
 4. Methods of discipline
 5. Illness, surgery, or trauma
- D. Adolescence
 1. Onset of puberty
 2. Academic achievement
 3. Organized activities (sports, clubs)
 4. Areas of special interest
 5. Romantic involvements and sexual experience
 6. Work experience
 7. Drug/alcohol use
 8. Symptoms (moodiness, irregularity of sleeping or eating, fights and arguments)
- E. Young adulthood
 1. Meaningful long-term relationship
 2. Academic and career decisions
 3. Military experience
 4. Work history
 5. Prison experience
 6. Intellectual pursuits and leisure activities
- F. Middle adulthood and old age
 1. Changing family constellation
 2. Social activities
 3. Work and career changes
 4. Aspirations
 5. Major losses
 6. Retirement and aging

Feeding Habits

Breast-fed or bottle-fed, eating problems

Early Development

Walking, talking, teething, language development, motor development, signs of unmet needs, sleep pattern, object constancy, stranger anxiety, maternal deprivation, separation anxiety, other caretakers in the home

Toilet Training

Age, attitude of parents, feelings about it

Symptoms of Behavior Problems

Thumb-sucking, temper tantrums, tics, head-bumping, rocking, night terrors, fears, bed-wetting or bed-soiling, nail-biting, excessive masturbation

Personality as a Child

Shy, restless, overactive, withdrawn, persistent, outgoing, timid, athletic, friendly, patterns of play

Middle Childhood (Ages 3 to 11 Years)

In addressing the middle childhood, the psychiatrist focuses on such important subjects as gender identification, punishments used in the home, and the persons who provided the discipline and influenced early conscience formation. The psychiatrist must inquire about the patient's early school experiences, especially how the patient first tolerated being separated from his or her mother. Data about the patient's earliest friendships and personal relationships are valuable. The psychiatrist should determine the number and the closeness of the patient's friends, describe whether the patient took the role of a leader or a follower, and describe the patient's social popularity and participation in group or gang activities. Was the child able to cooperate with peers, to be fair, to understand and comply with rules, and to develop an early conscience? Early patterns of assertion, impulsiveness, aggression, passivity, anxiety, or antisocial behavior emerge in the context of school relationships. A history of the patient's learning to read and developing other intellectual and motor skills is important. A history of learning disabilities, their management, and their effects on the child is of particular significance. The presence of nightmares, phobias, bed-wetting, fire-setting, cruelty to animals, and excessive masturbation should also be explored.

Late Childhood (Puberty through Adolescence)

During late childhood, persons begin to develop independence from their parents through relationships with peers and group activities. The psychiatrist should attempt to ascertain the values of the patient's social groups and to determine who were the patient's idealized figures. This information provides useful clues about the patient's emerging self-image.

It is helpful to explore the patient's school history, relationships with teachers, and favorite studies and interests, both in school and in extracurricular areas. Ask about the patient's participation in sports and hobbies and inquire about any emotional or physical problems that may have first appeared during this phase. Examples of the types of questions that are commonly asked include the following: What was the patient's sense of personal identity? How extensive was the use of alcohol and other substances? Was the patient sexually active, and what was the quality of the sexual relationships? Was the patient interactive and involved with school and peers, or was he or she isolated, withdrawn, and perceived as odd by others? Did the patient have a generally intact self-esteem, or was there evidence of an inferiority complex? What was the patient's body image? Were there suicidal episodes? Were there problems in school, including excessive truancy? How did the patient use private time? What was the relationship with the parents? What were the feelings about the development of secondary sex characteristics? What was the response to menarche? What were the attitudes about dating, petting, crushes, parties, and sex games? One way to organize the diverse and large amount of information is to break late childhood into subsets of behavior (e.g., social relationships, school history, cognitive and motor development, emotional and physical problems, and sexuality), as described next.

Social Relationships

Attitudes toward sibling(s) and playmates, number and closeness of friends, leader or follower, social popularity, participation in group or gang activities, idealized figures, patterns of aggression, passivity, anxiety, antisocial behavior

School History

How far the patient progressed, adjustment to school, relationships with teachers, teacher's pet versus rebel favorite studies or interests, particular abilities or assets, extracurricular activities, sports, hobbies,

relations of problems or symptoms to any social period

Cognitive and Motor Development

Learning to read and other intellectual and motor skills, minimal cerebral dysfunction, learning disabilities their management and effects on the child

Emotional and Physical Problems

Nightmares, phobias, bed-wetting, running away, delinquency, smoking, alcohol or other substance use, anorexia, bulimia, weight problems, feelings of inferiority, depression, suicidal ideas and acts

Adulthood

Occupational History

The psychiatrist should describe the patient's choice of occupation, the requisite training and preparation, any work-related conflicts, and the long-term ambitions and goals. Also explore the patient's feelings about his or her current job and relationships at work (with authorities, peers, and, if applicable, subordinates) and describe the job history (e.g., number and duration of jobs, reasons for job changes, and changes in job status). What would the patient do for work if he or she could choose freely?

A 40-year-old physician in a successful general practice also had many business ventures in which he invested a great deal of the money he had earned from property development. The ventures frequently entangled him in legal disputes. He spent 12 to 14 hours in his medical office each day seeing patients, completed his charting and paperwork on weekends, and snatched odd moments to conduct complicated business transactions with his attorney. He was snappy and irritable with his family; he expected them to be at his beck and call and to notice his , ,self-sacrificing , on their behalf. Reducing his practice, taking on an associate, and limiting his business activities were all unacceptable to him.

Marital and Relationship History

The psychiatrist elicits a history of each marriage, legal or common law. Significant relationships with persons with whom the patient has lived for a protracted period are also included. The story of the marriage or long-term relationship should describe the evolution of the relationship, including the age of the patient at the beginning of the relationship. The areas of agreement and disagreement ,including money management, housing difficulties, the roles of in-laws, and attitudes toward raising children should be described. Other questions include: Is the patient currently in a long-term relationship? How long is the longest relationship that the patient has had? What is the quality of the patient's sexual relationship (e.g., is the patient's sexual life experienced as satisfactory or inadequate)? What does the patient look for in a partner? Can the patient initiate a relationship or approach someone with whom he or she feels attracted? How does the patient describe the current relationship in terms of its positive and negative qualities? How does the patient perceive failures of past relationships in terms of understanding what went wrong and who was or was not to blame?

A 32-year-old woman had a series of relationships in which she was ultimately abused, always emotionally and often physically and sexually. Despite her conscious intent to find a caring man with whom she could have a less abusive relationship, the pattern repeated itself. Her mother had been chronically beaten by her abusive father. She recalled that her mother warned her repeatedly, , ,A woman's role is to give in to her husband and put up with the crap as best we can. ,

Military History

The psychiatrist should inquire about the patient's general adjustment to the military, whether he or she saw combat or sustained an injury, and the nature of the discharge. Was the patient ever referred for psychiatric consultation, and did he or she incur any disciplinary action during the period of service?

A 22-year-old soldier returning from Vietnam claimed to have no memory of his last month in combat. He had been assigned to a squad conducting a long-range patrol; only three of eight soldiers returned alive. Through repeated amobarbital interviews conducted in a supportive setting, gradually and with much emotion he recalled that his squad had been ambushed, that early in the firefight he had killed two or three 12- or 13-year-old Vietnamese boys who were in the attacking group, and that at a certain point he turned and ran away, leaving one or two of his wounded buddies behind, who were pleading with him to help them.

Education History

The psychiatrist needs to have a clear picture of the patient's educational background. This information can provide clues about the patient's social and cultural background, intelligence, motivation, and any obstacles to achievement. For instance, a patient from an economically deprived background who never had the opportunity to attend the best schools and whose parents never graduated from high school shows strength of character, intelligence, and tremendous motivation by graduating from college. A patient who dropped out of high school because of violence and substance use displays creativity and determination by going to school at night to obtain a high school diploma while working during the day as a drug counselor. How far did the patient go in school? What was the highest grade or graduate level attained? What did the patient like to study, and what was the level of academic performance? How far did the other members of the patient's family go in school, and how do they compare with the patient's progress? What is the patient's attitude toward academic achievement?

Religion

The psychiatrist determines the religious background of both parents and the details of the patient's religious instruction. Was the family's attitude toward religion strict or permissive, and were there any conflicts between the parents over the child's religious education? The psychiatrist should trace the evolution of the patient's adolescent religious practices to present beliefs and activities. Does the patient have a strong religious affiliation, and, if so, how does this affiliation affect the patient's life? What does the patient's religion say about the treatment of psychiatric or medical illness? What is the religious attitude toward suicide?

Social Activity

The psychiatrist elicits information about the patient's social life and the nature of friendships, with an emphasis on the depth, duration, and quality of human relationships. What social, intellectual, and physical interests does the patient share with friends? What relationships does the patient have with persons of the same sex and the opposite sex? Is the patient essentially isolated and asocial? Does the patient prefer isolation, or is the patient isolated because of anxieties and fears about other people? Who visits the patient in the hospital and how frequently?

An attractive, successful 32-year-old woman reported having a long string of admiring suitors and a series of intimate sexual relationships since the age of 17. Although several of the suitors to whom she was strongly attracted had proposed marriage, she felt unable to commit herself; she was never sufficiently in love with any of them and hoped that she would someday meet , ,Mr. Perfect. ,

Current Living Situation

Ask the patient to describe where he or she lives in terms of the neighborhood and the residence as well as the number of rooms, the number of family members living in the home, and the sleeping arrangements. Inquire how issues of privacy are handled, with particular emphasis on parental and sibling nudity and bathroom arrangements. Also ask about the sources of family income and any financial hardships. If applicable, inquire about public assistance and the patient's feelings about it. If the patient has been hospitalized, have provisions been made so that he or she will not lose a job or an apartment? Ask who is caring for the children at home, who visits the patient in the hospital, and how frequently.

Legal History

Has the patient ever been arrested and, if so, for what? How many times? Was the patient ever in jail? For how long? Is the patient on probation, or are charges pending? Is the patient mandated to be in treatment as part of a stipulation of probation? Does the patient have a history of assault or violence? Against whom? Were weapons used? What is the patient's attitude toward the arrests or prison terms? An extensive legal history, as well as the patient's attitude toward it, may indicate antisocial trends or a litigious personality. An extensive history of violence may alert the psychiatrist to the potential for violence in the future.

Sexual History

Much of the history of infantile sexuality is not recoverable, although many patients can recall curiosities and sexual games played from the ages of 3 to 6 years. The psychiatrist should ask how the patient learned about sex and what he or she felt were parents' attitudes about sexual development. Also inquire whether the patient was sexually abused in childhood. Some material discussed in this section may also be covered in the section on adolescent sexuality. It is not important where in the history it is covered, as long as it is included.

The onset of puberty and the patient's feelings about this milestone are important. Adolescent masturbatory history, including the nature of the patient's fantasies and feelings about them, is of significance. Attitudes toward sex should be described in detail. Is the patient shy, timid, aggressive? Does the patient need to impress others and boast of sexual conquests? Did the patient experience anxiety in the sexual setting? Was there promiscuity? What is the patient's sexual orientation? The sexual history (Table 7.1-3) should include any sexual symptoms, such as anorgasmia, vaginismus, erectile disorder (impotence), premature or retarded ejaculation, lack of sexual desire, and paraphillias (e.g., sexual sadism, fetishism, voyeurism). Attitudes toward fellatio, cunnilingus, and coital techniques may be discussed. The topic of sexual adjustment should include a description of how sexual activity is usually initiated, the frequency of sexual relations, and sexual preferences, variations, and techniques. It is usually appropriate to inquire whether the patient has engaged in extramarital relationships and, if so, under what circumstances and whether the spouse knew of the affair. If the spouse did learn of the affair, the psychiatrist should ask the patient to describe what happened. The reasons underlying an extramarital affair are just as important as understanding its effect on the marriage. Attitudes toward contraception and family planning are important. What form of contraception does the patient use? The psychiatrist, however, should not assume that the patient uses birth control. If an interviewer asks a lesbian patient to describe what type of birth control she uses (on the assumption that she is heterosexual), the patient may surmise that the interviewer will not understand or accept her sexual orientation. A more helpful question is, "Do you need to use birth control?" or "Is contraception something that is part of your sexuality?"

Table 7.1-3 Sexual History

1. Screening questions
 - a. Are you sexually active?
 - b. Have you noticed any changes or problems with sex recently?
2. Developmental
 - a. Acquisition of sexual knowledge
 - b. Onset of puberty/menarche
 - c. Development of sexual identity and orientation
 - d. First sexual experiences
 - e. Sex in romantic relationship
 - f. Changing experiences or preferences over time
 - g. Sex and advancing age
 - h. Clarification of sexual problems
 - i. Desire phase
 - Presence of sexual thoughts or fantasies
 - When do they occur and what is their object?
 - Who initiates sex and how?
 - j. Excitement phase
 - Difficulty in sexual arousal (achieving or maintaining erections, lubrication), during foreplay and preceding orgasm
 - k. Orgasm phase
 - Does orgasm occur?
 - Does it occur too soon or too late?

How often and under what circumstances does orgasm occur?

If orgasm does not occur, is it because of not being excited or lack of orgasm despite being aroused?

1. Resolution phase

What happens after sex is over (e.g., contentment, frustration, continued arousal)?

The psychiatrist should ask whether the patient wants to mention other areas of sexual functioning and sexuality. Is the patient aware of the issues involved in safe sex? Does the patient have a sexually transmitted disease, such as herpes or AIDS? Does the patient worry about being HIV positive?

A woman reported that she was addicted to using perfume and that her coworkers began to comment on her excessive use. Analysis revealed that she believed she exuded an odor after she masturbated. She masturbated daily and used the perfume to mask the smell that she believed was apparent to others. The basis of her belief could be traced to severe guilt over her masturbatory practices. (Otto Fenichel, M.D.)

Fantasies and Dreams

Freud stated that dreams are the royal road to the unconscious. Repetitive dreams have particular value. If the patient has nightmares, what are their repetitive themes? Some of the most common dream themes are food, examinations, sex, helplessness, and feelings of impotence. Can the patient describe a recent dream and discuss its possible meanings? Fantasies and daydreams are another valuable source of unconscious material. As with dreams, the psychiatrist can explore and record details of the fantasy and attendant feelings.

What are the patient's fantasies about the future? If the patient could make any change in his or her life, what would it be? What are the patient's most common or favorite current fantasies? Does the patient experience daydreams? Are the patient's fantasies grounded in reality, or is the patient unable to tell the difference between fantasy and reality?

Values

The psychiatrist may inquire about the patient's system of values both social and moral, including values about work, money, play, children, parents, friends, sex, community concerns, and cultural issues. For instance, are children a burden or a joy? Is work a necessary evil, an unavoidable chore, or an opportunity? What is the patient's concept of right and wrong?

Mental Status Examination

The mental status examination is the part of the clinical assessment that describes the sum total of the examiner's observations and impressions of the psychiatric patient at the time of the interview. Whereas the patient's history remains stable, the patient's mental status can change from day to day or hour to hour. The mental status examination is the description of the patient's appearance, speech, actions, and thoughts during the interview. Even when a patient is mute, is incoherent, or refuses to answer questions, the clinician can obtain a wealth of information through careful observation. A mental status format is outlined in Table 7.1-4.

General Description

Appearance

In this category, the psychiatrist describes the patient's appearance and overall physical impression, as reflected by posture, poise, clothing, and grooming. If the patient appears particularly bizarre, the clinician may ask, "Has anyone ever commented on how you look?" "How would you describe how you look?" "Can you help me understand some of the choices you make in how you look?" Examples of items in the appearance category include body type, posture, poise, clothes, grooming, hair, and nails. Common terms used to describe appearance are healthy, sickly, ill at ease, poised, old looking, young looking, disheveled, childlike, and bizarre. Signs of anxiety are noted: moist hands, perspiring forehead, tense posture, wide eyes.

Attitude Toward Examiner

The patient's attitude toward the examiner can be described as cooperative, friendly, attentive, interested, frank, seductive, defensive, contemptuous, perplexed, apathetic, hostile, playful, ingratiating, evasive, or guarded; any number of other adjectives can be used. Record the level of rapport established.

Speech Characteristics

This part of the report describes the physical characteristics of speech. Speech can be described in terms of its quantity, rate of production, and quality. The patient may be described as talkative, garrulous, voluble, taciturn, unspontaneous, or normally responsive to cues from the interviewer. Speech can be rapid or slow, pressured, hesitant, emotional, dramatic, monotonous, loud, whispered, slurred, staccato, or mumbled. Speech impairments, such as stuttering, are included in this section. Any unusual rhythms (termed dysprosody) or accent should be noted. The patient's speech may be spontaneous.

Overt Behavior and Psychomotor Activity

Here is described both the quantitative and qualitative aspects of the patient's motor behavior. Included are mannerisms, tics, gestures, twitches, stereotyped behavior, echopraxia, hyperactivity, agitation, combativeness, flexibility, rigidity, gait, and agility. Describe restlessness, wringing of hands, pacing, and other physical manifestations. Note psychomotor retardation or generalized slowing of body movements. Describe any aimless, purposeless activity.

Mood and Affect

Mood

Mood is defined as a pervasive and sustained emotion that colors the person's perception of the world. The psychiatrist is interested in whether the patient remarks voluntarily about feelings or whether it is necessary to ask the patient how he or she feels. Statements about the patient's mood should include depth, intensity, duration, and fluctuations. Common adjectives used to describe mood include depressed, despairing, irritable, anxious, angry, expansive, euphoric, empty, guilty, hopeless, futile, self-contemptuous, frightened, and perplexed. Mood can be labile, fluctuating or alternating rapidly between extremes (e.g., laughing loudly and expansively one moment, tearful and despairing the next).

Affect

Affect can be defined as the patient's present emotional responsiveness, inferred from the patient's facial expression, including the amount and the range of expressive behavior. Affect may or may not be congruent with mood. Affect can be described as within normal range, constricted, blunted, or flat. In the normal range of affect can be variation in facial expression, tone of voice, use of hands, and body movements. When affect is constricted, the range and intensity of expression are reduced. In blunted affect, emotional expression is further reduced. To diagnose flat affect, virtually no signs of affective expression should be present; the patient's voice should be monotonous and the face should be immobile. Note the patient's difficulty in initiating, sustaining, or terminating an emotional response.

Appropriateness of Affect

The psychiatrist can consider the appropriateness of the patient's emotional responses in the context of the subject the patient is discussing. Delusional patients who are describing a delusion of persecution should be angry or frightened about the experiences they believe are happening to them. Anger or fear in this context is an appropriate expression. Psychiatrists use the term inappropriate affect for a quality of response found in some schizophrenia patients, in which the patient's affect is incongruent with what the patient is saying (e.g., flattened affect when speaking about murderous impulses).

Perception

Perceptual disturbances, such as hallucinations and illusions, can be experienced in reference to the self

or the environment. The sensory system involved (e.g., auditory, visual, taste, olfactory, or tactile) and the content of the illusion or the hallucinatory experience should be described. The circumstances of the occurrence of any hallucinatory experience are important; hypnagogic hallucinations (occurring as a person falls asleep) and hypnopompic hallucinations (occurring as a person awakens) have much less serious significance than other types of hallucinations. Hallucinations can also occur in particular times of stress for individual patients. Feelings of depersonalization and derealization (extreme feelings of detachment from the self or the environment) are other examples of perceptual disturbance.

Formication, the feeling of bugs crawling on or under the skin, is seen in cocaine use.

Examples of questions used to elicit the experience of hallucinations include the following: Have you ever heard voices or other sounds that no one else could hear or when no one else was around? Have you experienced any strange sensations in your body that others do not seem to see?

A young man with schizophrenia heard an insistent voice repeatedly telling him to stop his antipsychotic medication. After resisting the command for many weeks, the patient felt that he could no longer fight the voice, and he discontinued treatment. Two months later, he was hospitalized involuntarily and near cardiovascular collapse. He later said that once he stopped the medication, the voice further insisted that he should stop eating and drinking to purify himself.

A terrified 37-year-old man in acute delirium tremens glanced agitatedly about the room. He pointed out the window and said: , My God, the Spanish armada is on the lawn. They're about to attack. , He experienced the hallucination as real, and it persisted intermittently for 3 days before abating. Subsequently, the patient had no memory of the experience.

Thought Content and Mental Trends

Thought can be divided into process (or form) and content. Process refers to the way in which a person puts together ideas and associations, the form in which a person thinks. Process or form of thought can be logical and coherent or completely illogical and even incomprehensible. Content refers to what a person is actually thinking about: ideas, beliefs, preoccupations, obsessions. Table 7.1-5 lists common thought disorders.

Thought Process (Form of Thinking)

The patient may have either an overabundance or a poverty of ideas. There may be rapid thinking, which, if carried to the extreme, is called a flight of ideas. A patient may exhibit slow or hesitant thinking.

Thought can be vague or empty. Do the patient's replies really answer the questions asked, and does the patient have the capacity for goal-directed thinking? Are the responses relevant or irrelevant? Is there a clear cause-and-effect relation in the patient's explanations? Does the patient have loose associations (e.g., do the ideas expressed seem unrelated and idiosyncratically connected)? Disturbances of thought continuity include statements that are tangential, circumstantial, rambling, evasive, or perseverative.

Table 7.1-5 Formal Thought Disorders

Circumstantiality. Overinclusion of trivial or irrelevant details that impede the sense of getting to the point.

Clang associations. Thoughts are associated by the sound of words rather than by their meaning (e.g., through rhyming or assonance).

Derailment. (Synonymous with loose associations.) A breakdown in both the logical connection between ideas and the overall sense of goal-directedness. The words make sentences, but the sentences do not make sense.

Flight of ideas. A succession of multiple associations so that thoughts seem to move abruptly from idea to idea; often (but not invariably) expressed through rapid, pressured speech.

Neologism. The invention of new words or phrases or the use of conventional words in idiosyncratic ways.

Perseveration. Repetition of out of context of words, phrases, or ideas.

Tangentiality. In response to a question, the patient gives a reply that is appropriate to the general topic without actually answering the question. Example:

Doctor: , ,Have you had any trouble sleeping lately? ,

Patient: , ,I usually sleep in my bed, but now I'm sleeping on the sofa. ,

Thought blocking. A sudden disruption of thought or a break in the flow of ideas.

Blocking is interruption of the train of thought before an idea has been completed; the patient may indicate an inability to recall what was being said or intended to be said. Circumstantiality indicates the loss of capacity for goal-directed thinking; in the process of explaining an idea, the patient brings in many irrelevant details and parenthetical comments but eventually does get back to the original point. Tangentiality is a disturbance in which the patient loses the thread of the conversation, pursues divergent thoughts stimulated by various external or internal irrelevant stimuli, and never returns to the original point. Thought process impairments may be reflected by incoherent or incomprehensible connections of thoughts (word salad), clang associations (association by rhyming), punning (association by double meaning), and neologisms (new words created by the patient by combining or condensing other words).

Thought Content

Disturbances in content of thought include delusions, preoccupations (which may involve the patient's illness), obsessions (, ,Do you have ideas that are intrusive and repetitive? ,), compulsions (, ,Are there things you do over and over, in a repetitive manner? , , ,Are there things you must do in a particular way or order? , , ,If you do not do them that way, must you repeat them? , , ,Do you know why you do things that way? ,), phobias, plans, intentions, recurrent ideas about suicide or homicide, hypochondriacal symptoms, and specific antisocial urges.

A patient had the compulsion to do everything eight times, which permeated all his behavior whether it was brushing his teeth or locking the door to his house each of which he had to do eight times. He knew his behavior was irrational but could not stop himself from this activity.

Does the patient have thoughts of doing self-harm? Is there a plan? A major category of disturbances of thought content involves delusions. Delusions .fixed, false beliefs out of keeping with the patient's cultural background ,may be mood congruent (thoughts that are in keeping with a depressed or elated mood, e.g., a depressed patient thinks he is dying or an elated patient thinks she is the Virgin Mary) or mood incongruent (e.g., an elated patient thinks he has a brain tumor). The psychiatrist should describe the content of any delusional system and attempt to evaluate its organization and the patient's conviction about its validity. The manner in which it affects the patient's life is appropriately described in the history of the present illness. Delusions can be bizarre and may involve beliefs about external control. Delusions can have themes that are persecutory or paranoid, grandiose, jealous, somatic, guilty, nihilistic, or erotic. The clinician should describe ideas of reference and of influence. Examples of ideas of reference include a person's belief that the television or radio is speaking to or about him or her. Examples of ideas of influence are beliefs about another person or force controlling some aspect of one's behavior.

A young man with schizophrenia, a college dropout who could work only part time at low-level jobs and who lived with his high-achieving family, believed he was the Messiah. He was fully convinced that his struggles and lack of occupational success were merely God's tests until the patient's true identity would be revealed. As he improved, he would, if asked, say that he was God's chosen but, when questioned further, would admit the slight possibility that he was wrong. On reaching his best clinical state, he would muse on the possibility that he was the Messiah but state that he was not sure.

Sensorium and Cognition

The sensorium and cognition portion of the mental status examination seeks to assess brain function, including intelligence, capacity for abstract thought, and level of insight and judgment. Questions that

test cognitive function are listed in Table 7.1-6.

Consciousness

Disturbances of consciousness usually indicate organic brain impairment. Clouding of consciousness is an overall reduced awareness of the environment. A patient may be unable to sustain attention to environmental stimuli or to maintain goal-directed thinking or behavior. Clouding or obtunding of consciousness is frequently not a fixed mental state. A patient typically exhibits fluctuations in the level of awareness of the surrounding environment. The patient who has an altered state of consciousness often shows some impairment of orientation as well, although the reverse is not necessarily true. Some terms used to describe the patient's level of consciousness are clouding, somnolence, stupor, coma, lethargy, or alert.

Table 7.1-6 Questions Used to Test Cognitive Functions in the Sensorium Section of the Mental Status Examination

1. Alertness	(Observation)
2. Orientation	What is your name? Who am I? What place is this? Where is it located? What city are we in?
3. Concentration	Starting at 100, count backward by 7 (or 3). Say the letters of the alphabet backward starting with Z. Name the months of the year backward starting with December.
4. Memory	
Immediate	Repeat these numbers after me: 1, 4, 9, 2, 5.
Recent	What did you have for breakfast? What were you doing before we started talking this morning? I want you to remember these three things: a yellow pencil, a cocker spaniel, and Cincinnati. After a few minutes I'll ask you to repeat them.
Long term	What was your address when you were in the third grade? Who was your teacher? What did you do during the summer between high school and college?
5. Calculations	If you buy something that costs \$3.75 and you pay with a \$5 bill, how much change should you get? What is the cost of three oranges if a dozen oranges cost \$4.00?
6. Fund of knowledge	What is the distance between New York and Los Angeles? What body of water lies between South America and Africa?
7. Abstract reasoning	Which one does not belong in this group: a pair of scissors, a canary, and a spider? Why? How are an apple and an orange alike?

Orientation and Memory

Disorders of orientation are traditionally separated according to time, place, and person. Any impairment usually appears in this order (i.e., sense of time is impaired before sense of place); similarly, as the patient improves, the impairment clears in the reverse order. The psychiatrist must determine whether a patient can give the approximate date and time of day. In addition, if hospitalized, does the patient know how long he or she has been there? Does the patient seem to be oriented to the present? In questions about orientation to place, patients should be able to state the name and the location of the hospital correctly and to behave as though they know where they are. In assessing orientation for person, the psychiatrist asks patients whether they know the names of the people around them and whether they understand their roles in relationship to them. Do they know who the examiner is? Only in the most severe instances do patients not know who they themselves are.

A 42-year-old alcoholic man in delirium tremens, examined in a California hospital in 1995, was asked the date and where he was. He replied: , I'm standing on a street corner in Kansas City in 1966 minding my own business. Why don't you mind yours? ,

Memory functions have traditionally been divided into four areas: remote memory, recent past memory, recent memory, and immediate retention and recall. Recent memory can be checked by asking patients about their appetite and then about what they had for breakfast or for dinner the previous evening. Patients can be asked at this point if they recall the interviewer's name. Asking patients to repeat six digits forward and then backward is a test of immediate retention. Remote memory can be tested by asking patients for information about their childhood that can be verified later. Asking patients to recall important news events from the past few months checks recent past memory. Often in cognitive disorders, recent or short-term memory is impaired first, and remote or long-term memory is impaired later. If there is impairment, what efforts are made to cope with it or to conceal it? Is denial, confabulation, or circumstantiality used to conceal a deficit? Reactions to the loss of memory can give important clues to underlying disorders and coping mechanisms. For instance, a patient who appears to have memory impairment but, in fact, is depressed is more likely to be concerned about memory loss than is someone with memory loss secondary to dementia. The clinician must also determine whether a catastrophic reaction is present (anxious crying when unable to remember).

A 40-year-old chronically alcoholic man, whose memory on the mental status examination was markedly impaired, frantically demanded to be released from the hospital, saying that his wife had just been in an automobile accident and that he had to rush to another hospital to see her. He said it with sincere conviction and appropriate fearful concern; for the patient, at least, the story was real. In fact, his wife had been dead for 15 years. The patient told the same story over and over again, always with evident conviction, despite that staff members confronted him with the reality that his wife had been dead for years. The patient was never influenced by their assertions, because he could not register new memories. Although his past memory was patchy at best, he could repeatedly recall the story of his wife's emergency.

Table 7.1-7 Summary of Memory Tests

Try to assess whether the process of registration, retention, or recollection of material is involved.

Remote memory: Childhood data, important events known to have occurred when the patient was younger or free of illness, personal matters, neutral material

Recent past memory: The past few months

Recent memory: The past few days, what the patient did yesterday, the day before, what the patient had for breakfast, lunch, dinner

Immediate retention and recall: Digit-span measures; ability to repeat six figures after examiner dictates them ,first forward, then backward (patients with unimpaired memory can usually repeat six digits backward); ability to repeat three words immediately and 3 to 5 minutes later

Confabulation (unconsciously making up false answers when memory is impaired) is most closely associated with cognitive disorders.

Table 7.1-7 gives a summary of memory tests.

Concentration and Attention

A patient's concentration can be impaired for many reasons. A cognitive disorder, anxiety, depression, and internal stimuli, such as auditory hallucinations, can all contribute to impaired concentration.

Subtracting serial 7s from 100 is a simple task that requires intact concentration and cognitive capacities. Could the patient subtract 7 from 100 and keep subtracting 7s? If the patient could not

subtract 7s, could 3s be subtracted? Were easier tasks accomplished: 4 ÷ 9, 5 ÷ 4? The examiner must always assess whether anxiety, some disturbance of mood or consciousness, or a learning deficit (dyscalculia) is responsible for the difficulty.

Attention is assessed by calculations or by asking the patient to spell the word world (or others) backward. The patient can also be asked to name five things that start with a particular letter.

During his most recent manic episode, a 48-year-old man with bipolar disorder had intense, grandiose, psychotic ideas. He was convinced that he could control the traffic in Los Angeles by driving on certain freeways at specified times and willing others to leave the road. After the manic episode ended and during the depressive episode that immediately followed, he could recall virtually no details of his previous thought content while he was manic. Later, when euthymic, he remembered only a few hazy images. A year later, the beginning of a new hypomanic period was heralded by the patient's spontaneously remembering and describing in great detail the psychotic plans of the previous episode.

Reading and Writing

The psychiatrist should ask the patient to read a sentence. The patient should also be asked to write a simple but complete sentence.

Visuospatial Ability

The patient should be asked to copy a figure, such as a clock face or interlocking pentagons.

Abstract Thought

Abstract thinking is the ability to deal with concepts. Patients can have disturbances in the manner in which they conceptualize or handle ideas. Can the patient explain similarities, such as those between an apple and a pear or between truth and beauty? Are the meanings of simple proverbs, such as , A rolling stone gathers no moss, , understood? Answers can be concrete (giving specific examples to illustrate the meaning) or overly abstract (giving too generalized an explanation). The appropriateness of answers and the manner in which they are given should be noted. In a catastrophic reaction, brain-damaged patients become extremely emotional and cannot think abstractly.

When asked to explain the proverb , People in glass houses should not throw stones , a schizophrenic patient replied, , That's easy, you can break the glass. ,

Information and Intelligence

If a possible cognitive impairment is suspected, does the patient have trouble with mental tasks, such as counting the change from \$10 after a purchase of \$6.37? If this task is too difficult, are easy problems (such as how many nickels are in \$1.35) solved? The patient's intelligence is related to vocabulary and general fund of knowledge (e.g., the distance from New York to Paris, presidents of the United States). The patient's educational level (both formal and self-education) and socioeconomic status must be taken into account. Handling difficult or sophisticated concepts can reflect intelligence, even in the absence of formal education or an extensive fund of information. Ultimately, the psychiatrist estimates the patient's intellectual capability and capacity to function at the level of basic endowment.

Impulsivity

Is the patient capable of controlling sexual, aggressive, and other impulses? An assessment of impulse control is critical in ascertaining the patient's awareness of socially appropriate behavior and is a measure of the patient's potential danger to self and others. Patients may be unable to control impulses secondary to cognitive and psychotic disorders or because of chronic characterological defects, as observed in the personality disorders. Impulse control can be estimated from information in the patient's recent history and from behavior observed during the interview.

Judgment and Insight

Judgment

During the course of history taking, the psychiatrist should be able to assess many aspects of the patient's capability for social judgment. Does the patient understand the likely outcome of his or her behavior, and is he or she influenced by this understanding? Can the patient predict what he or she would do in imaginary situations (e.g., smelling smoke in a crowded movie theater)?

When asked what she would do if she found a stamped addressed envelope on the street, the patient replied, "Well, I would open it of course and read what it said. Maybe there would be money in it."

Insight

Insight is a patient's degree of awareness and understanding about being ill. Patients may exhibit complete denial of their illness or may show some awareness that they are ill but place the blame on others, on external factors, or even on organic factors. They may acknowledge that they have an illness but ascribe it to something unknown or mysterious in themselves.

An 18-year-old man went to an emergency room with the belief that he was controlled by a computer on an Enterprise-like starship, an elaboration from the television series Star Trek. He was convinced that all his thoughts, actions, and feelings were being programmed onboard the starship, which was located light years away and, therefore, could never be detected by anyone else.

Intellectual insight is present when patients can admit that they are ill and acknowledge that their failures to adapt are partly because of their own irrational feelings. Patients' inability to apply their knowledge to alter future experiences, however, is the major limitation to intellectual insight. True emotional insight is present when patients' awareness of their own motives and deep feelings leads to a change in their personality or behavior patterns.

A summary of six levels of insight follows:

- Complete denial of illness
- Slight awareness of being sick and needing help, but denying it at the same time
- Awareness of being sick but blaming it on others, on external factors, or on organic factors
- Awareness that illness is caused by something unknown in the patient
- Intellectual insight: admission that the patient is ill and that symptoms or failures in social adjustment are caused by the patient's own particular irrational feelings or disturbances without applying this knowledge to future experiences
- True emotional insight: emotional awareness of the motives and feelings within the patient and the important persons in his or her life, which can lead to basic changes in behavior.

Reliability

The mental status part of the report concludes with the psychiatrist's impressions of the patient's reliability and capacity to report his or her situation accurately. It includes an estimate of the psychiatrist's impression of the patient's truthfulness or veracity. For instance, if the patient is open about significant active substance abuse or about circumstances that the patient knows may reflect badly (e.g., trouble with the law), the psychiatrist may estimate the patient's reliability to be good.

Psychiatric Report

The psychiatric report is a written document that details the findings obtained from the psychiatric history and mental status examination. A detailed outline of the psychiatric report is found in Table 7.1-8. It includes a final summary of both positive and negative findings and an interpretation of the data. It has more than descriptive value; it has meaning that helps provide an understanding of the case. The examiner addresses critical questions in the report: Are future diagnostic studies needed and, if so, which ones? Is a consultant needed? Is a comprehensive neurological workup needed, including an electroencephalogram or computerized tomography scan? Are psychological tests indicated? Are psychodynamic factors relevant? The report includes a diagnosis made according to the revised fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), which uses a multi-axial classification scheme consisting of five axes, each of which should be covered (see Table 9.1-7 in Section 9.1). A prognosis is also discussed in the report, with both good and bad prognostic factors listed. Finally, a treatment plan discusses, and makes firm recommendations about, management issues.

Practical Aspects of the Psychiatric Interview

Session Length

The initial consultation lasts for 30 minutes to 1 hour, depending on the circumstances. Interviews with patients who are psychotic or medically ill are brief because patients may find the interview stressful. Similarly, emergency room interviews vary in length. Initial interviews to evaluate patients for pharmacotherapy or psychotherapy tend to be longer; second visits and ongoing therapeutic interviews vary in length. The American Board of Psychiatry and Neurology, in its clinical oral examination in psychiatry, allows 30 minutes for candidates to conduct a psychiatric examination.

Patients' management of appointment times reveals important aspects of personality and coping. Most often, patients arrive a few minutes before their appointments. An anxious patient may arrive as much as 30 minutes early. When a patient arrives very early, the clinician may want to explore the reasons. The patient who arrives significantly late for an appointment also poses potential questions. The first time a patient is late, the clinician can listen to the explanation offered and respond sympathetically if the lateness is because of circumstances beyond the patient's control. A patient who states, "I forgot all about the appointment," however, is offering a clue that there is something about going to the doctor that makes that patient anxious or uncomfortable. This reaction needs to be explored further. The psychiatrist may ask, "Did you feel reluctant to come in today?" If the answer is, "Yes," the psychiatrist can begin to explore the possible reasons for the patient's reluctance. If the answer is, "No," it is probably best to drop the direct questioning about the lateness and just listen to the patient. By listening carefully, the psychiatrist can usually detect themes that the patient may not recognize. These themes can then be explored by both the patient and the psychiatrist in an attempt to understand better what the patient is experiencing.

Table 7.1-8 Psychiatric Report

I. Psychiatric History

- A. **Identification:** Name, age, marital status, sex, occupation, language if other than English, race, nationality, and religion if pertinent; previous admissions to a hospital for the same or a different condition; with whom the patient lives
- B. **Chief complaint:** Exactly why the patient came to the psychiatrist, preferably in the patient's own words; if that information does not come from the patient, note who supplied it
- C. **History of present illness:** Chronological background and development of the symptoms or behavioral changes that culminated in the patient's seeking assistance; patient's life circumstances at the time of onset; personality when well; how illness has affected life activities and personal relations, changes in personality, interests, mood, attitudes toward others, dress, habits, level of tenseness, irritability, activity, attention, concentration, memory, speech; psychophysiological symptoms, nature and details of dysfunction; pain, location, intensity, fluctuation; level of anxiety, generalized and nonspecific (free floating) or specifically related to particular situations, activities, or objects; how anxieties are handled, avoidance, repetition of feared situation, use of drugs or other activities for alleviation
- D. **Past psychiatric and medical history:** (1) Emotional or mental disturbances, extent of incapacity, type of treatment, names of hospitals, length of illness, effect of treatment; (2) psychosomatic disorders: hay fever, arthritis, colitis, rheumatoid arthritis, recurrent colds, skin conditions; (3) medical conditions: follow customary review of systems, sexually transmitted diseases, alcohol or other substance abuse, at risk for acquired immunodeficiency syndrome (AIDS); (4) neurological disorders: headache, craniocerebral trauma, loss of consciousness, seizures or tumors

- E. **Family history:** Elicited from patient and from someone else, since quite different descriptions may be given of the same persons and events; ethnic, national, and religious traditions; other persons in the home, descriptions of them ,personality and intelligence ,and what has become of them since patient's childhood; descriptions of different households lived in; present relationships between patient and those who were in family; role of illness in the family; family history of mental illness; where does patient live ,neighborhood and particular residence of the patient; is home crowded; privacy of family members from each other and from other families; sources of family income and difficulties in obtaining it; public assistance (if any) and attitude about it; will patient lose job or apartment by remaining in the hospital; who is caring for children
- F. **Personal history (anamnesis):** History of the patient's life from infancy to the present to the extent it can be recalled; gaps in history as spontaneously related by the patient; emotions associated with different life periods (painful, stressful, conflictual) or with phases of life cycle
1. Early childhood (Birth through age 3)
 - a. Prenatal history and mother's pregnancy and delivery: Length of pregnancy, spontaneity and normality of delivery, birth trauma, whether patient was planned and wanted, birth defects
 - b. Feeding habits: Breast-fed or bottle-fed, eating problems
 - c. Early development: Maternal deprivation, language development, motor development, signs of unmet needs, sleep pattern, object constancy, stranger anxiety, separation anxiety
 - d. Toilet training: Age, attitude of parents, feelings about it
 - e. Symptoms of behavior problems: Thumb sucking, temper tantrums, tics, head bumping, rocking, night terrors, fears, bed-wetting or bed soiling, nail biting, masturbation
 - f. Personality and temperament as a child: Shy, restless, overactive, withdrawn, studious, outgoing, timid, athletic, friendly patterns of play, reactions to siblings
 2. Middle childhood (ages 3 to 11): Early school history ,feelings about going to school, early adjustment, gender identification, conscience development, punishment; social relationships, attitudes toward siblings and playmates
 3. Later childhood (prepuberty through adolescence)
 - a. Peer relationships: Number and closeness of friends, leader or follower, social popularity, participation in group or gang activities, idealized figures; patterns of aggression, passivity, anxiety, antisocial behavior
 - b. School history: How far the patient went, adjustment to school, relationships with teachers ,teacher's pet or rebellious , favorite studies or interests, particular abilities or assets, extracurricular activities, sports, hobbies, relationships of problems or symptoms to any school period
 - c. Cognitive and motor development: Learning to read and other intellectual and motor skills, minimal cerebral dysfunction, learning disabilities ,their management and effects on the child
 - d. Particular adolescent emotional or physical problems: Nightmares, phobias, masturbation, bed-wetting, running away, delinquency, smoking, drug or alcohol use, weight problems, feeling of inferiority
 - e. Psychosexual history
 - i. Early curiosity, infantile masturbation, sex play
 - ii. Acquiring of sexual knowledge, attitude of parents toward sex,

- sexual abuse
 - iii. Onset of puberty, feelings about it, kind of preparation, feelings about menstruation, development of secondary sexual characteristics
 - iv. Adolescent sexual activity: Crushes, parties, dating, petting, masturbation, wet dreams and attitudes toward them
 - v. Attitudes toward same and opposite sex: Timid, shy, aggressive, need to impress, seductive, sexual conquests, anxiety
 - vi. Sexual practices: Sexual problems, homosexual and heterosexual experiences, paraphilias, promiscuity
 - f. Religious background: Strict, liberal, mixed (possible conflicts), relation of background to current religious practices
4. Adulthood
- a. Occupational history: Choice of occupation, training, ambitions, conflicts; relations with authority, peers, and subordinates; number of jobs and duration; changes in job status; current job and feelings about it
 - b. Social activity: Whether patient has friends or not; is patient withdrawn or socializing well; social, intellectual, and physical interests; relationships with same sex and opposite sex; depth, duration, and quality of human relations
 - c. Adult sexuality
 - i. Premarital sexual relationships, age of first coitus, sexual orientation
 - ii. Marital history: Common-law marriages, legal marriages, description of courtship and role played by each partner, age at marriage, family planning and contraception, names and ages of children, attitudes toward raising children, problems of any family members, housing difficulties if important to the marriage, sexual adjustment, extramarital affairs, areas of agreement and disagreement, management of money, role of in-laws
 - iii. Sexual symptoms: Anorgasmia, impotence, premature ejaculation, lack of desire
 - iv. Attitudes toward pregnancy and having children; contraceptive practices and feelings about them
 - v. Sexual practices: Paraphilias such as sadism, fetishes, voyeurism; attitude toward fellation, cunnilingus; coital techniques, frequency
 - d. Military history: General adjustment, combat, injuries, referral to psychiatrists, type of discharge, veteran status
 - e. Value systems: Whether children are seen as a burden or a joy; whether work is seen as a necessary evil, an avoidable chore, or an opportunity; current attitude about religion; belief in heaven and hell

Summation of the examiner's observations and impressions derived from the initial

II. Mental Status

A. Appearance

1. Personal identification: May include a brief nontechnical description of the patient's appearance and behavior as a novelist might write it; attitude toward examiner can be described here, cooperative, attentive, interested, frank, seductive, defensive, hostile, playful, ingratiating, evasive, guarded
2. Behavior and psychomotor activity: Gait, mannerisms, tics, gestures, twitches,

stereotypes, picking, touching examiner, echopraxia, clumsy, agile, limp, rigid, retarded, hyperactive, agitated, combative, waxy

3. General description: Posture, bearing, clothes, grooming, hair, nails; healthy, sickly, angry, frightened, apathetic, perplexed, contemptuous, ill at ease, poised, old looking, young looking, effeminate, masculine; signs of anxiety, moist hands, perspiring forehead, restlessness, tense posture, strained voice, wide eyes; shifts in level of anxiety during interview or with particular topic

B. Speech: Rapid, slow, pressured, hesitant, emotional, monotonous, loud, whispered, slurred, mumbled, stuttering, echolalia, intensity, pitch, ease, spontaneity, productivity, manner, reaction time, vocabulary, prosody

C. Mood and affect

1. Mood (a pervasive and sustained emotion that colors the person's perception of the world): How does patient say he or she feels; depth, intensity, duration, and fluctuations of mood, depressed, despairing, irritable, anxious, terrified, angry, expansive, euphoric, empty, guilty, awed, futile, self-contemptuous, anhedonic, alexithymic
2. Affect (the outward expression of the patient's inner experiences): How examiner evaluates patient's affects, broad, restricted, blunted or flat, shallow, amount and range of expression; difficulty in initiating, sustaining, or terminating an emotional response; is the emotional expression appropriate to the thought content, culture, and setting of the examination; give examples if emotional expression is not appropriate

D. Thinking and perception

1. Form of thinking
 - a. Productivity: Overabundance of ideas, paucity of ideas, flight of ideas, rapid thinking, slow thinking, hesitant thinking; does patient speak spontaneously or only when questions are asked, stream of thought, quotations from patient
 - b. Continuity of thought: Whether patient's replies really answer questions and are goal directed, relevant, or irrelevant; loose associations; lack of causal relations in patient's explanations; illogical, tangential, circumstantial, rambling, evasive, perseverative statements, blocking or distractibility
 - c. Language impairments: Impairments that reflect disordered mentation, such as incoherent or incomprehensible speech (word salad), clang associations, neologisms
2. Content of thinking
 - a. Preoccupations: About the illness, environmental problems; obsessions, compulsions, phobias; obsessions or plans about suicide, homicide; hypochondriacal symptoms, specific antisocial urges or impulses
3. Thought disturbances
 - a. Delusions: Content of any delusional system, its organization, the patient's convictions as to its validity, how it affects his or her life: persecutory delusions, isolated or associated with pervasive suspiciousness; mood-congruent or mood-incongruent
 - b. Ideas of reference and ideas of influence: How ideas began, their content, and the meaning the patient attributes to them
4. Perceptual disturbances
 - a. Hallucinations and illusions: Whether patient hears voices or sees visions;

- content, sensory system involvement, circumstances of the occurrence; hypnagogic or hypnopompic hallucinations; thought broadcasting
 - b. Depersonalization and derealization: Extreme feelings of detachment from self or from the environment
5. Dreams and fantasies
- a. Dreams: Prominent ones, if patient will tell them; nightmares
 - b. Fantasies: Recurrent, favorite, or unshakable daydreams

E. Sensorium

1. Alertness: Awareness of environment, attention span, clouding of consciousness, fluctuations in levels of awareness, somnolence, stupor, lethargy, fugue state, coma
2. Orientation
 - a. Time: Whether patient identifies the day correctly; or approximate date, time of day; if in a hospital, knows how long he or she has been there; behaves as though oriented to the present
 - b. Place: Whether patient knows where he or she is
 - c. Person: Whether patient knows who the examiner is and the roles or names of the persons with whom in contact
3. Concentration and calculation: Subtracting 7 from 100 and keep subtracting 7s; if patient cannot subtract 7s, can easier tasks be accomplished ,4 Æ— 9; 5 Æ— 4; how many nickels are in \$1.35; whether anxiety or some disturbance of mood or concentration seems to be responsible for difficulty
4. Memory: Impairment, efforts made to cope with impairment ,denial, confabulation, catastrophic reaction, circumstantiality used to conceal deficit: whether the process of registration, retention, or recollection of material is involved
 - a. Remote memory: Childhood data, important events known to have occurred when the patient was younger or free of illness, personal matters, neutral material
 - b. Recent past memory: Past few months
 - c. Recent memory: Past few days, what did patient do yesterday, the day before, have for breakfast, lunch, dinner
 - d. Immediate retention and recall: Ability to repeat six figures after examiner dictates them ,first forward, then backward, then after a few minutes' interruption; other test questions; did same questions, if repeated, call forth different answers at different times
 - e. Effect of defect on patient: Mechanisms patient has developed to cope with defect
5. Fund of knowledge: Level of formal education and self-education; estimate of the patient's intellectual capability and whether capable of functioning at the level of his or her basic endowment; counting, calculation, general knowledge; questions should have relevance to the patient's educational and cultural background
6. Abstract thinking: Disturbances in concept formation; manner in which the patient conceptualizes or handles his or her ideas; similarities (e.g., between apples and pears), differences, absurdities; meanings of simple proverbs (e.g., , ,A rolling stone gathers no moss ,) answers may be concrete (giving specific examples to illustrate the meaning) or overly abstract (giving generalized explanation); appropriateness of answers

F. Insight: Degree of personal awareness and understanding of illness

1. Complete denial of illness
2. Slight awareness of being sick and needing help but denying it at the same time
3. Awareness of being sick but blaming it on others, on external factors, on medical or unknown organic factors
4. Intellectual insight: Admission of illness and recognition that symptoms or failures in social adjustment are due to irrational feelings or disturbances, without applying that knowledge to future experiences
5. True emotional insight: Emotional awareness of the motives and feelings within, of the underlying meaning of symptoms; does the awareness lead to changes in personality and future behavior; openness to new ideas and concepts about self and the important persons in his or her life

G. Judgment

1. Social judgment: Subtle manifestations of behavior that are harmful to the patient and contrary to acceptable behavior in the culture; does the patient understand the likely outcome of personal behavior and is patient influenced by that understanding; examples of impairment
2. Test judgment: Patient's prediction of what he or she would do in imaginary situations (e.g., what patient would do with a stamped, addressed letter found in the street)

III. Further Diagnostic Studies

- A. Physical examination
- B. Neurological examination
- C. Additional psychiatric diagnostic
- D. Interviews with family members, friends, or neighbors by a social worker
- E. Psychological, neurological, or laboratory tests as indicated: Electroencephalogram, computed tomography scan, magnetic resonance imaging, tests of other medical conditions, reading comprehension and writing tests, test for aphasia, projective or objective psychological tests, dexamethasone-suppression test, 24-hour urine test for heavy metal intoxication, urine screen for drugs of abuse

IV. Summary of Findings

Summarize mental symptoms, medical and laboratory findings, and psychological and neurological test results, if available; include medications patient has been taking, dosage, duration. Clarity of thinking is reflected in clarity of writing. When summarizing the mental status (e.g., the phrase , Patient denies hallucinations and delusions , is not as precise as , Patient denies hearing voices or thinking that he is being followed.). The latter indicates the specific question asked and the specific response given. Similarly, in the conclusion of the report one would write , Hallucinations and delusions were not elicited. ,

V. Diagnosis

Diagnostic classification is made according to DSM-IV-TR, which uses a multiaxial classification scheme consisting of five axes, each of which should be covered in the diagnosis
Axis I: Clinical syndromes (e.g., mood disorders, schizophrenia, generalized anxiety disorder) and other conditions that may be a focus of clinical attention

Axis II: Personality disorders, mental retardation, and defense mechanisms

Axis III: Any general medical conditions (e.g., epilepsy, cardiovascular disease, endocrine disorders)

Axis IV: Psychosocial and environmental problems (e.g., divorce, injury, death of a loved one) relevant to the illness

Axis V: Global assessment of functioning exhibited by the patient during the interview (e.g., social, occupational, and psychological functioning); a rating scale with a continuum from 100 (superior functioning) to 1 (grossly impaired functioning) is used

VI. Prognosis

Opinion about the probable future course, extent, and outcome of the disorder; good and bad prognostic factors; specific goals of therapy

VII. Psychodynamic Formulation

Causes of the patient's psychodynamic breakdown, influences in the patient's life that contributed to present disorder; environmental, genetic, and personality factors relevant to determining patient's symptoms; primary and secondary gains; outline of the major defense mechanism used by the patient

VIII. Comprehensive Treatment Plan

Modalities of treatment recommended, role of medication, inpatient or outpatient treatment, frequency of sessions, probable duration of therapy; type of psychotherapy; individual, group, or family therapy; symptoms or problems to be treated. Initially, treatment must be directed toward any life-threatening situations such as suicidal risk or risk of danger to others that require psychiatric hospitalization. Danger to self or others is an acceptable reason (both legally and medically) for involuntary hospitalization. In the absence of the need for confinement, a variety of outpatient treatment alternatives are available: day hospitals, supervised residences, outpatient psychotherapy or pharmacotherapy, among others. In some cases, treatment planning must attend to vocational and psychosocial skills training and even legal or forensic issues. Comprehensive treatment planning requires a therapeutic team approach using the skills of psychologists, social workers, nurses, activity and occupational therapists, and a variety of other mental health professionals, with referral to self-help groups (e.g., Alcoholics Anonymous [AA]) if needed. If either the patient or family members are unwilling to accept the recommendations of treatment and the clinician thinks that the refusal of the recommendations may have serious consequences, the patient, parent, or guardian should sign a statement to the effect that the recommended treatment was refused.

A psychiatrist's handling of time is also an important factor in the interview. Carelessness about time indicates a lack of concern for the patient. If a psychiatrist is unavoidably detained for an interview, it is appropriate to express regret at having kept the patient waiting.

Seating and Arrangement of Office

The arrangement of chairs in the psychiatrist's office affects the interview. Both chairs should be of approximately equal height, so that neither person looks down on the other. Most psychiatrists think that it is desirable to place the chairs without any furniture between the clinician and the patient. If the room contains several chairs, the psychiatrist indicates his or her own chair and then allows the patient to choose the chair in which he or she will feel most comfortable.

The evaluation should be conducted in a comfortable room with pleasant lighting. Better rapport can be established and fuller observations made if the psychiatrist is not sitting behind a desk. Although no reason exists to make the room impersonal, dramatic paintings, spectacular, panoramic views, or expensive antiques may distract the patient. A comfortable waiting area should be provided for patients who arrive early.

A psychiatrist can never remain entirely unknown to patients, and the office can tell patients a good deal about the doctor's personality. The colors in the office, paintings and diplomas on the wall, the furniture, plants, books, and personal photographs all describe the psychiatrist in ways that are not directly verbalized. Patients often have reactions to their doctors' offices that may or may not be

distortions, and carefully listening to any comments can help a psychiatrist understand the patient. Studies have shown that patients respond more positively to male physicians who wear jackets and ties than to those who do not. No studies have been done on the dress of female physicians, but, by extrapolation, professional attire would probably elicit a positive response.

Types of Interventions

Psychiatrists do much more during an interview than ask questions. They provide feedback and information, offer reassurances, and respond emotionally to what the patient is saying. The psychiatrist's facial expression and body posture also convey information to the patient. Interventions are described as , ,supportive , or , ,obstructive, , depending on the extent to which they increase the flow of information and enhance or diminish rapport. Table 7.1-9 contains examples of both.

The concept of supportive and obstructive interventions has broad, general use, but it cannot be applied rigidly. The psychiatric interview is a complex, multifaceted task that is shaped by the personalities and circumstances of the interview. Above all, it is a human endeavor. The personality of the interviewer is an inevitable and desirable component of the interview and it need not to be veiled behind a mask of austerity or indifference. The concept of , ,neutrality , as proposed in psychoanalytic psychiatry means that the psychiatrist does not take sides in the patient's intrapsychic conflicts. It does not mean the clinician is a nonresponding robot.

Table 7.1-9 Supportive and Obstructive Interventions

Supportive

Acknowledging emotion

Doctor: , ,Even after all these years, talking about your mother brings tears to your eyes. ,

Encouragement

Patient: , ,I've never been very good at putting things into words. ,

Doctor: , ,I think you've described the situation well ,in a way that helps me understand what you have been going through. ,

Reassurance

Doctor: , ,The hopelessness you feel right now seems overwhelming. I think it is very likely with the proper treatment you can get back to feeling yourself. ,

Nonverbal

Facial expression and body posture that convey interest, concern, and attentiveness.

Obstructive

Compound questions

Doctor: , ,Do you take a vacation every year, and are you able to relax? ,

Trapping the patient in his or her own words

Doctor: , ,When I asked you before, you said nothing had gone well over the last year, and now you are telling me you got a raise and have been exercising more. ,

Why questions

Doctor: , ,Why do you keep waking up so early in the morning? ,

Dismissal or minimization

Patient: , ,Over the last month I have had trouble with sex. ,

Doctor: , ,That happens from time to time. ,

Premature advice

Patient: , ,Ever since my girlfriend and I split up last year, I cannot seem to meet anyone new. ,

Doctor: , ,Why not try spending time in bookstores and coffee houses? There are usually lots of single people in those places. ,

Not following the patient's lead

Doctor: , ,How long have you been feeling so sad? ,

Patient: , ,Over 6 months. Nothing is getting better. I am starting to wonder if it is worth it. ,

Doctor: , ,Do you have trouble sleeping through the night? ,

Judgmental

Doctor: , ,Have you been using any drugs? ,

Patient: , ,Well besides drinking, I smoke a little grass on weekends. ,

Doctor: , ,Do you not know that marijuana can cause serious problems with motivation over the long term? ,

Nonverbal

Facial expression, body posture, and behavior that indicate lack of interest or inattentiveness, such as yawning, or checking one's watch. The doctor who shows no emotional reaction to what a patient is saying usually conveys a sense of not listening or being uninterested.

Ending the Interview

At the end of the evaluation, the psychiatrist must give the patient his or her impressions and suggestions, even if they are preliminary. Patients seeing a psychiatrist for the first time are often apprehensive. They wonder if they are , ,crazy, , if their problems can be understood, if they will be judged, and most importantly whether they can be helped. Although patients can experience significant relief just in talking with another person about their concerns, these fears should be explicitly addressed and realistic reassurance offered about available treatments. The concluding moments of the initial interview prepare the patient for follow-up, and handling them well increases the likelihood of helping the patient. It is especially important to give persons who have become emotionally distraught a few minutes to collect themselves before they are asked to leave the office. For example, a psychiatrist might say to a patient who is sobbing heavily near the end of the interview, , ,It's clear these things are still very painful to talk about. We have to finish in a few minutes, but let me take a moment to give you my impressions and tell you what I think is best to do next. ,

Note Taking

For legal and medical reasons, an adequate written record of each patient's treatment must be maintained. The patient's record also aids the psychiatrist's memory. Each clinician must establish a system of record keeping and decide which information to record. Many psychiatrists make complete notes during the first few sessions while eliciting historical data. Afterward, most psychiatrists record only new historical information, important events in the patient's life, medications prescribed, dreams, and general comments about the patient's progress. Some psychiatrists maintain detailed process notes (verbatim record of a session) for specific patients by writing out immediately after a session as much of the session as they can remember. Process notes make it much easier to determine trends in the treatment (with regard to transference and countertransference issues) and to go back over the session to pick up ideas that may have been missed. Process notes are also helpful if a psychiatrist is working with a supervisor or a consultant who needs an accurate presentation of a particular session. Most psychiatrists do not recommend taking extensive notes during a session; writing can cut down on the ability to listen. Some patients, however, may express resentment if a psychiatrist does not write notes during an interview; they may fear that their comments were not important enough to record or that the psychiatrist was not interested in them. Because not taking notes during a session presumably has no relation to the psychiatrist's listening, this feeling on a patient's part can be further explored to understand the fear of not being taken seriously.

An increasing number of psychiatrists are communicating with patients through e-mail. E-mail has the advantages of being quick, usually brief, and often less disruptive than telephone calls. As a result, e-mail communication often feels more spontaneous and casual than a telephone call or letter. For all their apparent casualness, e-mail messages, however, constitute a formal part of the treatment record and are subject to review in court proceedings.

Stress Interview

A stress interview has its advocates and has a minor place in the armamentarium of interview techniques. Most patients feel some anxiety or other emotion when talking to a psychiatrist. Through his or her manner or a word of reassurance or praise the psychiatrist can often decrease this emotion so that the patient can continue to tell his or her story. Certain patients, however, are monotonously repetitious or show insufficient emotion for motivation. Apathy, indifference, and emotional blunting are not conducive to discussion of personality problems. In patients with such reactions, stimulation of emotions can be constructive. These patients may require probing, challenging, or confrontation to arouse feelings that will promote progress in furthering understanding. For example, the la belle indifférence of the hysteric may be converted into anxiety so that the patient can experience sufficient discomfort to talk about his or her conflicts.