CHAPTER 7. DIAGNOSIS AND PSYCHIATRY: EXAMINATION OF THE PSYCHIATRIC PATIENT

7.1 PSYCHIATRIC INTERVIEW, HISTORY, AND MENTAL STATUS EXAMINATION

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Psychiatric Evaluation
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The purpose of a psychiatric diagnostic interview is to gather information that will enable the examiner to make a diagnosis. Having established a diagnosis, the clinician can then make predictions about the future course of a disorder and the likely response to treatment. As with all areas of medicine, treatment decisions are guided by diagnosis. Unlike most disciplines of physical medicine, however, psychiatry has no external validating criteria, no laboratory tests to confirm or refute diagnostic impressions. Consequently the diagnosis is wholly a product of the skills and knowledge of the individual psychiatrist and can never be better than the judgment made by individual clinicians.

Because of the absence of external validating criteria or biologic markers, diagnostic reliability is an intrinsic problem in clinical psychiatry. Before 1980 the problem was compounded by official diagnostic descriptions that were narrative and impressionistic. Schizophrenia was overdiagnosed in the United States because the description failed to distinguish it sufficiently from mood disorders with psychotic symptoms. Starting with the third edition of *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) of the American Psychiatric Association (APA) in 1980 and through subsequent editions and revisions, diagnostic criteria have been based on descriptive phenomenology of clinical symptoms and clinical course. The move away from interpretive, intuitive, and impressionistic diagnoses has succeeded in improving diagnostic reliability. It has also strengthened the medical model of psychiatry.

Medical Model and Psychodynamic Formulation The medical model has become the dominant mode of psychiatry in the United States and much of the rest of the world. In this model psychiatrists are seen as physicians who specialize in the treatment of psychiatric disorders. The function of the diagnostic

interview is to gather sufficient information to establish a categorical diagnosis or diagnoses. The diagnosis is used to predict the future course of a disorder and its likely response to treatment, and it is the foundation for all subsequent therapeutic decisions.

In contrast, the adaptational model sees psychiatrists as specialists in behavior and adaptation whose expertise can benefit people whether or not they have a diagnosable psychiatric disorder. Psychoanalytic psychiatry is an example of this model. A psychoanalytic interview is less concerned with establishing a diagnosis than with surveying psychological functions as they have evolved over an individual's lifetime.

A psychodynamic formulation draws from the principles of psychoanalytic theory. It describes personality structure in terms of ego strengths (including principal defense mechanisms, regulation of drives, relationships with other people, and reality testing), principal psychological conflicts, and developmental history, with particular emphasis on early childhood. The psychodynamic formulation is not intended to produce a diagnosis but rather to describe an array of psychological and adaptive capacities. These descriptions allow the analytic psychiatrist to formulate a theoretical model that explains current symptomatic behavior and interpersonal or functional limitations. It serves as the template for the conduct of a psychoanalytic therapy by anticipating unconscious intrapsychic conflicts and unacknowledged developmental arrests or delays.

The psychodynamic formulation differs from a diagnostic interview using the medical model in several significant aspects. It is more concerned with the unique characteristics of the particular individual than with commonalties of a diagnostic class. The data of a psychodynamic formulation are overwhelmingly interpretive and inferential. Defense mechanisms cannot be seen; their existence can only be inferred from observed (or described) behavior. Moreover, the psychodynamic formulation is inextricably tied to a single theoretical school. Prior understanding of psychoanalytic theory is prerequisite to making the formulation, and experienced analysts may offer different formulations from the same data.

In clinical practice psychiatric assessments are likely to draw from both analytic and medical models and are shaped by the unique circumstances of individual patients. There are patients for whom a psychodynamic formulation is relatively more important and will thus take up a greater portion of the interview. Among these are persons being considered for a psychodynamic therapy or those with a constellation of complaints not subsumed in a conventional categorical diagnosis. There are also persons for whom a psychodynamic formulation may be of negligible importance, for example, an individual with a diagnosis of obsessive-compulsive disorder or simple phobia in which the planned therapies are pharmacological and behavioral rather than psychodynamic. However, even in these circumstances many psychiatrists prefer to have some sense of a person's psychological makeup and developmental history to avoid focusing on symptom relief to the exclusion of other areas of potential concern and to deal with resistances to therapy as they arise. The principles of psychoanalytic theory may offer a workable model for organizing and using these concepts.

PSYCHIATRIC EVALUATION

The psychiatric evaluation comprises two sections. The first, a section of histories (e.g., psychiatric, medical, family) includes the patient's description of how symptoms of the current episode have evolved, a review of past episodes and treatments, a description of current and past medical conditions, a summary of family members' psychiatric problems and treatments, and the patient's personal history, which reveals interpersonal and adaptive functioning over time. Information for the history will come from the patient but may be supplemented by collateral information from family members, social referral agencies, previous treating physicians, and old hospital records. The second section of the psychiatric evaluation, the mental status examination, systematically reviews emotional and cognitive functioning of the patient at the time the interview is conducted. Diagnostic criteria in DSM-IV draw from both the history and the mental status examination. An outline of the psychiatric assessment is presented in Table 7.1-1.

Table 7.1-1 Psychiatric History and Mental Status Examination

PSYCHIATRIC HISTORY

Identification The identification establishes the basic demographics of the patient. It includes age and sex, frequently includes racial or ethnic information, and occasionally includes religious affiliation. It is not necessary to list family, social, occupational, and educational information covered more fully in the personal history unless such information has direct diagnostic relevance. For example, although military service would not routinely be mentioned, it would be helpful to mention that a patient is an excombatant when posttraumatic stress disorder is being considered. (The case from which the following examples are taken was provided by Richard Nathanson.)

> This is the first psychiatric hospital admission for Mr. A., a 21-year-old bisexual male employed part-time as a veterinarian's assistant. He currently lives with his boyfriend and has never been married.

Chief Complaint The chief complaint is a verbatim recording of the patient's reason for seeking treatment or evaluation. Putting the chief complaint in the patient's own words, even if implausible or nonsensical, conveys valuable information about the person's capacity for insight and self-observation.

"I took an overdose of some pills but I'm fine now."

History of the Present Illness This section is a chronological description of how symptoms in the current episode have unfolded over time. The psychiatrist needs to determine not only the nature of symptoms, but also when they emerged and how they have progressed. The characteristics of symptoms should be described in detail; small distinctions may be diagnostically useful. Stating that a patient suffers from insomnia is less useful than describing the insomnia. Difficulty in falling asleep, difficulty in maintaining sleep, and a decreased need for sleep are each associated with different disorders. Attention should be paid to pertinent negatives as well as pertinent positives. In a patient complaining of depression, for example, the absence of vegetative symptoms is significant and should be mentioned. Whether the patient has been in treatment, has been taking any psychotropic medication, and has (or has not) been compliant are essential elements of the history of the present illness. If a patient has stopped taking a prescribed medication the reasons should be determined. Noncompliance is a symptom that needs to be investigated and not simply dismissed as poor judgment or character weakness. Noncompliance has many possible causes: unpleasant adverse effects, failure to understand the necessity for chronic medication despite symptomatic improvement, insufficiently treated symptoms such as the fear of being poisoned by medication, a reluctance to see oneself as psychiatrically impaired, or simply lacking the transportation and money to get a prescription refilled. Any current alcohol or other substance use should be described, including amounts, frequency, and last use. It is also useful to ask why the person came for treatment at this time, and what the patient believes to be causing the present symptoms.

The patient is a 21-year-old male with a history of one prior suicide attempt who was brought to the hospital emergency room by ambulance, accompanied by his boyfriend and roommate, after having taken an overdose of atenolol (Tenormin) (twenty-five 25-mg tablets), zolpidem (Ambien) (twenty 10-mg tablets), and possibly fluoxetine (Prozac) pills (number unknown) in a suicide attempt. All of these medications had been prescribed for the patient's boyfriend.

The evening before, the patient had had a fight with his boyfriend. He believed that his boyfriend wasn't giving him enough time and was not committed to the relationship. They slapped and punched each other. The patient went to a bar with another friend where he consumed four beers and a shot of vodka. When he arrived back at home, his boyfriend told him to go to sleep, which he interpreted as a continued lack of interest on the boyfriend's part. He locked himself in the bathroom and took many of his boyfriend's pills. The patient filled the empty pill bottles with water and left them in plain view on the sink.

The patient then unlocked the door and went to bed, telling his boyfriend where to find syrup of ipecac. (Mr. A. carries the ipecac in his knapsack to induce vomiting when he drinks too much alcohol.) His boyfriend saw the pill bottles, realized the patient had overdosed, and tried to induce vomiting by administering syrup of ipecac. Unable to get the patient to vomit, he called an ambulance.

> Mr. A currently drinks alcohol once or twice each week, usually on the weekends. A usual amount of alcohol for him consists of two vodka tonics and eight or nine beers. Often, he drinks until he blacks out. He used cocaine this past New Year's Eve ("a few lines") and occasionally uses heroin intransally (unknown amounts). He denies any history of intravenous drug use.
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> He remembers always speaking and thinking very quickly, because he was always "so bright and talented and good looking and smart." In addition, he has needed little sleep since age 15. The racing thoughts, pressured speech, and decreased need for sleep have become more pronounced since September, when he started feeling "very up." Since then he has been getting at most 5 hours of sleep each night without feeling tired. He says he can be very influential, but that he has no special powers. He reports that he gets angry quickly and that his mood can change very easily. Since September he's also felt more depressed and physically restless. He considers suicide frequently, "just to escape the boredom of life." He has lost 6 pounds in the last 2 months. There is no history of hallucinations or of delusional thought.

Past Psychiatric History The past psychiatric history describes all previous episodes and symptoms whether treated or not. The history should begin with the first onset of symptoms and progress chronologically to the current episode. It describes symptoms in detail and clearly delineates their longitudinal progress. Disorders that are chronic and relapsing are distinguished from isolated episodes of disturbance. It is particularly important to obtain the fullest possible information on prior treatments. The best predictor of treatment response is past experience. If a person has taken psychiatric medication before, it is essential to determine not only which drug, but the dosage and length of treatment, to distinguish nonresponse from a subtherapeutic drug trial. Therapeutic benefits and adverse effects should be noted. Similarly, if a patient has received psychotherapy it is important to establish which modality of therapy, at what frequency, for what length of time, and with what benefit.

> The patient has a history of violent outbursts. His mother reports that as an infant, he would bang his head against the floor. Throughout his childhood, he got into fights with other children and would even attack family members and teachers. In seventh grade, he threw a chair at a teacher. Once he attacked his older brother and kicked him in the head repeatedly until he lost consciousness and required medical attention. During his senior year in high school, the patient was forced to see the school therapist because of a heated argument with a teacher. The teacher claimed that the patient tried to hit him, and though the patient denied this, he was expelled. He met with the psychologist five or six times and stopped treatment when he graduated. There is a history of one previous suicide attempt 2 years ago, precipitated by the infidelity of his first boyfriend. The patient fashioned a noose and began to hang himself. When he began to feel pain, he stopped. He never told anyone about this attempt and never sought or received treatment. Psychotropic medication has never been prescribed.

Medical History The importance of a thorough, accurate medical history is difficult to overstate. The occurrence of major illness or surgery is likely to be of considerable significance in a person's life and may be the precipitant of psychiatric disturbance. For example, in response to having a heart attack, a

middle-aged man might develop anxiety, depression, and a fear of sex. In addition, many medical conditions and their treatments cause psychiatric symptoms that are clinically indistinguishable from primary psychiatric disorders. Hypoglycemia can cause panic and anxiety; hypercalcemia, depression and lethargy; and acute porphyria, psychotic symptoms. Moreover, the presence of underlying medical conditions will inform treatment decisions: tricyclic antidepressants will be avoided in patients with cardiac conduction abnormalities, and bipolar I disorder patients with a history of renal disease are more likely to be treated with an anticonvulsant than with lithium. The names and dosing schedules for all currently prescribed nonpsychiatric drugs should be obtained to avoid possible adverse interactions with any new prescription.

In many instances the findings from a current physical examination and laboratory studies will be important in the diagnostic assessment. This is always true of hospitalized psychiatric patients, and may be necessary for selected outpatients. Few primary psychiatric disorders include physical signs. (One exception is panic disorder, which may include tachypnea, tachycardia, hypertension, and dilated pupils.) Their presence always warrants medical evaluation. Aspects of the clinical history may also suggest the need for medical investigation: abrupt onset of symptoms in an older adult with no prior psychiatric history, symptoms atypical for purely psychiatric disorders (e.g., vomiting and diarrhea or shaking chills), or a history of recent illness or treatment. In addition, abnormalities of the sensorium section of the mental status examination are most typical of delirium and dementia and indicate the need to look for underlying medical conditions.

> The patient has had streptococcal pharyngitis five times in the past 4 years. At age 15, he fractured his right wrist in a fight. He denies any other medical conditions. He takes no medications and has no known drug allergies. He has never been hospitalized or undergone any surgical procedures.

Family History Many psychiatric disorders are familial, and many of those appear to have a genetic component to the cause. Knowing who is in the patient's family and which, if any, psychiatric disorders have been diagnosed may help in diagnosis and treatment planning. Caution is urged however against overinterpretation of such data. Experienced clinicians are good at establishing the presence of a family psychiatric history but are less able to identify specific disorders in family members not personally interviewed. Even when specific disorders can be clearly identified, the information is of limited use because our knowledge of spectrum disorders—that is, which disorders occur together in families and the relative risk of their occuring together—is still embryonic. On the other hand, the family history can clearly show who is in the family, who is available for support, who may be exacerbating symptoms, whether a general vulnerability to psychiatric disorders exists, and what stresses have been caused by a family member's illness. It is also useful to establish which treatments have been attempted and which have been successful; treatment response is often familial.

> The patient's immediate family consists of his father (age 51), his mother (age 49), one older brother (age 26), and one younger sister (age 19). His father suffers from alcohol dependence. Family history is otherwise negative for psychiatric disorders, medical disease, dementia, addiction, suicide attempts, and violence.

Personal History The personal history is intended to describe events of major significance throughout a person's life, to highlight those that may be etiologically significant, and to describe functioning over time. Which elements of the personal history are important will vary from patient to patient and cannot easily be prescribed. The information presented in the personal history will be shaped by other information from the interview. The psychiatrist will make ongoing clinical judgments about what is important and what is not. Major items commonly include early childhood friendships, education and any changes in school performance, romantic involvements, work history, military or jail experiences, and leisure activities.

The personal history may or may not include a detailed developmental history. A full development history begins with significant events and complications during pregnancy and delivery. Was the pregnancy full term? Did the patient's mother use drugs or alcohol during the pregnancy? Were there prenatal complications? Milestones of development in infancy and childhood (walking, talking, bowel and bladder control) can be described, although the information may be lacking or unreliable if the adult patient is the only source of information. Social development in childhood is revealed through information about friendships, schooling, and extracurricular activities. Often of considerable use is the patient's recollections of intrafamilial relationships including their relationships with each other and each separately with the patient.

A landmark of adolescence is the onset of puberty. The age of menarche, the circumstance of its onset, and preparations are likely to be significant emotional events in the lives of women. The growth of pubic and axillary hair signals the onset of puberty for boys. Late-onset puberty often has significant emotional and social consequences for boys: they are often less confident, more self-conscious, and less likely to be widely popular or leaders in school. Early experiences in dating, first sexual experiences, and any confusion or discomfort about sexual orientation are all important aspects of adolescent development.

Adolescence is also often a time of first drug experimentation. Information about which drugs, how much, how often, and under what circumstances should be obtained as well as changing patterns of drug or alcohol use. The development of career goals, undertaking advanced education, starting a first job, entering the military, and establishing a partnership (including marriage) all signify the transition from adolescence to adulthood.

Development continues through an individual's lifetime. The changes in adulthood are less likely to be as clearly demarcated or as universal as the developmental milestones of childhood or adolescence, but for many people the achievement of career and family goals will predominate. The examiner should inquire about current relationships, whether the patient is currently married and has ever been married before. Qualitative descriptions of interpersonal relations are important in diagnosing personality disorders and assessing suitability for some kinds of psychotherapy. In addition, recent research has drawn attention to the importance of strong, emotional, personal bonds in maintaining both physical and mental health.

The review of a patient's work history includes a summary of the jobs held, the length of time in each,

and the reasons for leaving. Of considerable importance is the possible discrepancy between aspiration and achievement. The examiner should determine the extent to which psychopathology has interfered with the capacity for sustained productive work.

It is useful to ask patients what they do with their free time. Avocational, recreational, and humanitarian pursuits are important in the lives of many adults, and their absence may be diagnostically significant. For some people, military or prison history is important. As adults grow older, new issues such as children leaving home, the death of one's parents, retirement, and the loss of friends will emerge.

Some writers have advocated obtaining a detailed developmental history for all patients (at least one writer argues for inclusion of a detailed prenatal history), but such information is rarely of use in formulating a diagnosis or planning treatment for adult patients. Unlike a psychoanalytic assessment, which may be stretched over several sessions and which attempts to be comprehensive in its survey of developing character traits and ego strengths, a clinical diagnostic interview is more focused. A solid knowledge of psychopathology shapes the interview as it progresses. It is difficult to justify the time and expense of obtaining a detailed developmental history for a person with, for example, a simple phobia, obsessive-compulsive disorder, or panic disorder. Such information is necessary neither for establishing the diagnosis, nor for prescribing and implementing effective treatment.

On the other hand, describing functional capacity over time is necessary and useful. Deteriorating school performance, an irregular work history with failure to progress to higher levels of responsibility, premature discharge from the military, an inability to sustain friendships or romantic involvements for any period of time, may all have diagnostic and prognostic significance. The distinction between schizophrenia and bipolar disorder, both chronic, relapsing conditions with the possibility of psychotic symptoms, was first made on the basis of deterioration in the former and stability of function in the latter. Personality disorders that by definition attempt to identify core *trait* features will present with characteristic difficulties in interpersonal relationships or work capacity relatively unchanged over the course of a lifetime. The personal history may contain information helpful in making a prognosis as well as diagnosis. For example, a good premorbid adjustment reflected in school and work history indicates a good prognosis in patients diagnosed with schizoaffective disorder.

The personal history also helps identify key events that may have helped precipitate current symptoms: divorce, loss of work, death of a family member, serious financial setbacks. However, with the exception of posttraumatic stress disorder, identification of a precipitating event is not required to make a diagnosis. It may be useful although not necessary. Sexual functioning should be reviewed in the personal history. Basic screening questions include whether the patient is currently sexually active, who are preferred partners, whether there has been a change in sexual functioning, and the extent to which sex is pleasurable. If sexual difficulties emerge, more detailed questions can follow. When complaints of sexual disturbances do occur, the information is likely to be more appropriate for the history of the present illness than for the personal history.

The patient grew up in a medium-size city. His relationships with family members have always been difficult. While he often got into physical fights with his brother and his father, there is no history of physical, verbal, or sexual abuse.

In school, he had difficulty controlling his behavior, getting into fights and cursing a great deal. He was a good student when he worked, receiving As and Bs and honors in middle school and in the ninth grade. He failed all of his classes in the sophomore year and needed to repeat the year. He attributed this to ignoring school and partying too much. During his last year of high school, he attended a special arts school, studying drama and jazz. He graduated from high school after 5 years.

He had trouble making friends. He had a girlfriend for 2½ years in high school, but they broke up because they argued too much. He met his first boyfriend at age 17, but this boy cheated on him, precipitating the previous suicide attempt. In the past 2 or 3 years, the patient has found himself primarily attracted to men but still considers himself bisexual.

After high school, he lived with his parents for almost 2 years. During that time, he played drums in a band and held part-time jobs as a sales clerk. These jobs never lasted more than a few months, usually ending in verbal fights with his employer. He applied to music school but was not accepted because of his poor high school performance. Six months before admission, he moved to a large city to live with his uncle, hoping to take classes without credit. Lack of financial resources required him to work instead. He worked for 24 hours each week, off the books, as a veterinarian's assistant. He felt that his uncle was too controlling and domineering and moved in with another friend in October. In November, he met his current boyfriend, Mr. B., at a bar. A week and a half later, he moved into the boyfriend's house in the suburbs. Mr. B. reports that his relationship with the patient has been characterized by extreme suspiciousness and neediness. The patient has recurrent thoughts that his boyfriend doesn't care about him and is cheating on him, even though there is no evidence.

The patient has no savings and is supported by his boyfriend. His parents have severe financial difficulties and are unable to help him. Contact with family members is presently limited to his mother and his aunt because he doesn't get along with any other family members.

The patient has had about 25 different sexual partners, about half male and half female. He does not always practice safe sex and has engaged in high-risk behaviors such as receptive anal sex without using a condom. Because of this, he has been tested for human immunodeficiency virus (HIV) infection four times. The result was negative each time, most recently 2 months before admission.

There is a significant history of substance abuse. During his second and third years in high school, he smoked marijuana two to three times each week. He stopped after graduation and has since smoked marijuana only two or three times. He used cocaine once in high school and only

occasionally in the past 2 years, snorting a few lines each time. He has used lysergic acid diethylamide (LSD) and phencyclidine (PCP) but never regularly. He has smoked cigarettes since age 13, ranging from half a pack to 2½ packs a day. He stopped smoking for 9 months 3 years ago but resumed and currently smokes half a pack a day.

MENTAL STATUS EXAMINATION

The mental status examination of psychiatric patients is analogous to the physical examination in physical medicine. It provides a format for the systematic observation and recording of information about a person's thinking, emotions, and behavior. These data combined with information from the history are the basis for formulating a differential diagnosis. As is true for the physical examination, a physician conducting a mental status examination notes only those findings present at the time of interview. Historical information is excluded. A patient may report having had auditory hallucinations the day before, but unless they are present when the examination is conducted, hallucinations are not recorded in the mental status examination.

The physician must also be as objective as possible in making mental status observations. Since 1980 the various editions of DSM have emphasized descriptive phenomenology in making psychiatric diagnoses to the exclusion of inferred, intrapsychological processes, in an explicit attempt to enhance diagnostic reliability. Observed data are always more reliable than inferred data. Correspondingly, the mental status examiner should strive to record findings that are as free of interpretation or inference as possible.

The formal organization of the mental status examination ensures completeness. In the actual interview of a psychiatric patient it is seldom necessary to proceed with an inflexible, prescribed series of questions. Much of the mental status examination is observational and can be made in the course taking the history. There are several specific tests of cognitive function, but much of this information can be obtained simply by talking with a patient. The experienced clinician does several things simultaneously in conducting a psychiatric interview: establishing rapport, eliciting important historical information, recognizing areas of greater or lesser emotional intensity, and making ongoing mental status observations.

ORGANIZATION OF THE MENTAL STATUS EXAMINATION

Numerous variations on the mental status examination have been described. The specific format matters less than ensuring that the observations are complete and logically organized to facilitate diagnosis. The outline presented here and summarized in Table 7.1-1 is widely used.

Appearance A brief description is given of the patient's appearance, behavior, and manner of relating to the examiner, with particular attention paid to abnormalities. Is the patient overdressed or underdressed? Is the patient wearing excessive, garish make-up? Is the patient disheveled, unkempt, or ungroomed? Is the patient cooperative, oppositional, hostile, seductive, or impassive? Are there unusual movements? Is the patient making smacking or chewing motions? Is there a tremor? Is the patient pacing? Although a

comprehensive psychiatric assessment always includes a physical examination, obvious signs of physical illness (e.g., pallor, jaundice, labored breathing, or dilated pupils) are also mentioned under "appearance."

> The patient is a muscular young man appearing his stated age, wearing jeans, a white t-shirt, and sneakers. He wears several rings on his fingers and bracelets on both wrists. There is an obvious healing cut on his upper lip, which is slightly swollen. He is unshaven, but has an overall neat appearance and adequate hygiene. He sits with his arms crossed in a chair that swivels and uses his feet to swivel through roughly 90 degrees back and forth throughout the interview. He maintains good eye contact.

Speech The speech section of the mental status examination describes the physical production of speech, not the ideas being conveyed. Observations may be made about volume, rate, spontaneity, syntax, and vocabulary. Any speech abnormality such as dysarthria or aphasia is described. The speech of a manic patient may be loud and pressured. Conversely, the speech of a depressed patient may be soft and hesitant.

> He speaks spontaneously and very rapidly, becoming pressured at times, but he is interruptible. Volume is occasionally loud. Rhythm and expressive intonation are normal. Speech is understandable, but some words are poorly articulated because of the high rate of speech production.

Emotional Expression It has been a convention for many years to describe emotional expression in terms of mood and affect, and those terms are still used extensively. Mood has commonly been described as the prevailing emotional state, and affect as the expression and expressivity of a patient's emotions. The term *affect* derives from the psychoanalytical literature and was originally intended to describe the feeling tone accompanying ideas or mental representations of external objects. *Mood* in turn was believed to derive from the summation of affects. By definition, affect would fluctuate with an individual's changing thoughts. Mood was more constant over time.

In this author's opinion, there are compelling reasons to abandon the distinction between mood and affect and no longer include a description of affect in the mental status examination. In its original psychoanalytic meaning, affect could be inferred but not directly observed because it was an intrapsychological phenomenon.

Moreover, the neurobiology of mood disorders, as now understood, is far more complex than the product of feeling tones accompanying ideas. This was implicitly acknowledged in 1987 when the revised third edition DSM (DSM-III-R) replaced the category of affective disorders with mood disorders. In a diagnostic scheme that is phenomenologic-descriptive and atheoretical with regard to etiology, this author believes the concept of affect is an anomaly.

Equally important is the fact that *affect* has acquired multiple and sometimes contradictory meanings. The distinction between mood and affect tends to focus on two parameters: constancy versus change and internal versus external. There has been a tendency to link the two, so that what is constant and internal (mood) is distinguished from what is transitory and external (affect). This coupling does not conform to clinical reality. It is quite possible for an individual's subjective experience of emotion to shift rapidly (e.g., in some manic states or frontal lobe syndromes). It is also quite possible for the external expression of emotion to be unvarying despite changes in subjective experience, as for example is sometimes seen in the residual phase of schizophrenia. In addition to its different definitions, no research has shown that affect can be reliably rated even by experienced clinicians.

Rather than attempting to distinguish mood and affect, the author's position is that in the mental status examination it is preferable to describe subjective and objective components of emotional expression separately. The subjective component is how individuals describe their inner emotional state: I feel happy; I feel sad, anxious, hopeless, exhilarated, etc. The objective component describes the way in which emotion is communicated through facial expression, vocal tone, and body posture. The two may be discordant. A patient whose eyes are filling up with tears may describe himself as feeling "fine." Both objective and subjective components of emotion may fluctuate rapidly or remain unvarying. Both may be intense or blunted, and both may be appropriate or inappropriate to the topic being discussed. The long-term predisposition to jollity, melancholy, exuberance, or restraint is *temperament* rather than *mood*. Because the mental status examination describes only what is observed at the time of interview, an evaluation of temperament is not possible. As mentioned above however, the terms *mood* and *affect* are in common use and are to be found in most outlines of the psychiatric report and mental status.

> Subjectively he reports feeling angry and depressed because he is being kept on a locked ward. Objectively he appears tense, angry, and sad at different times. His emotional expression is labile, of full range, and appropriate to content. His eyes fill with tears at times.

Thinking and Perception If psychotic symptoms exist, they are most likely to be described in this section. *Thinking* is subdivided into two subcategories: form and content.

Thought Form *Thought form* refers to the way in which ideas are linked, not the ideas themselves. Thoughts may be logically associated and goal directed. If they are not, a disorder of thought form (also formal thought disorder or sometimes, thought disorder) may exist. A number of different formal thought disorders have been described and are listed in Table 7.1-2. No thought disorder is pathognomonic for a particular disorder. However, a specific disorder of thought form is sometimes more characteristic of one diagnosis than another and may thereby convey diagnostic significance. For example, clang associations and flight of ideas are most closely associated with manic states, derailment and thought blocking with schizophrenia.

Table 7.1-2 Formal Thought Disorders

His thoughts are generally logical and goal directed, although he is quite circumstantial, launching into emotional accounts of relevant ideas but including many irrelevant details. There is no evidence of flight of ideas, loosening of associations, perseveration, tangentiality, or thought blocking.

Thought Content *Thought content* describes a patient's ideas. Abnormalities of content include delusions, ideas of reference, and obsessions. *Delusions* are fixed, false beliefs that are not shared by others as part of a religious or subcultural group. They are rigidly held regardless of evidence to the contrary. Except for delusional disorders, the type of delusion is not pathognomonic but may be associated closely enough with a particular disorder to have diagnostic implications. For example, delusions of guilt and somatic delusions are characteristic of (but not unique to) major depression with psychotic features. Delusions of persecution may be seen in schizophrenia and mania.

The patient who believes that everyday neutral occurrences carry specific, unique, and personal significance is said to have *ideas of reference*. A person may believe, for example, that a television announcer is attempting to convey a hidden message or that a stranger passing by on the street is signaling something of significance by brushing his hair or blowing his nose. Depending on the fixity and details of the belief, some ideas of reference may also be delusional.

Obsessions are unwanted, intrusive thoughts experienced by patients as symptomatic and beyond their control. The content of an obsession may be virtually anything but is often a disturbing thought of doing something embarrassing, hurtful, or dangerous. For example a young father may have thoughts of his daughter being sexually molested, a middle-aged woman of shouting obscenities during a church service. Because of the effort to control their thinking and because patients with obsessions are often deeply chagrined by their content, it is necessary to inquire specifically about their presence and not rely on voluntary reporting. *Preoccupations* are thoughts that predominate a person's thinking but are usually not experienced as unwanted or symptomatic. Examples include preoccupations with health, with money or social status, or with injustices.

A careful psychiatric examination always includes an assessment of suicide potential—even if there is no evidence of suicidality in the history—and of the potential for violence toward others. It is best to ask simple and direct questions; for example, Do you think about hurting yourself or about taking your life? The evaluation of suicidality and violence are discussed more fully below.

> Mistrustful, suspicious thought is evident: He is preoccupied with thoughts that his boyfriend may have cheated on him. He also expresses extreme mistrust of the staff's motives, believing that the staff overanalyzes and carelessly misinterprets his statements and actions. He threatens to elope from the unit, claiming to know several ways to escape. He has inflated self-esteem, claiming to be extremely talented in a lot of areas, conceding that there are people who are better than he is, but that with a little practice, for example, he can be the best musician ever. He denies current suicidal or homicidal thoughts, intent, or plan.

Perception Perceptual abnormalities include hallucinations and illusions. Hallucinations are sensory perceptions generated wholly within the central nervous system (CNS) in the absence of any external stimulus. They can occur in any sensory modality: auditory, visual, tactile, olfactory, or gustatory. Auditory and visual hallucination are the most common. The modality of hallucination has no diagnostic significance, with the exception of *formication*, a tactile hallucination of insects crawling over or under the skin, which is strongly associated with withdrawal from alcohol and other central nervous system (CNS) sedatives. Illusions originate with true sensory stimuli, which are then misprocessed or misinterpreted. A patient looking at the shadows created on a wall by a rustling curtain may actually see threatening monsters. Illusions are widely believed to be more common in delirium than in other psychiatric disorders, despite the absence of empirical confirmation. Depersonalization and derealization (the sense that oneself or the world are not real) may also be recorded as perceptual abnormalities in the mental status examination.

> He described hearing a man's voice, muffled, but at times intelligible, saying his name or short phrases such as “they're wrong.” There was no evidence of hallucinations in any other modality.

Sensorium This section includes assessment of several cognitive functions that collectively describe the overall intactness of the CNS. Cognitive disorders such as the syndromes of delirium and dementia and psychiatric disorders caused by drugs or general medical conditions are particularly likely to result in abnormalities in the sensorium. The set of cognitive functions described in this section are subserved by different brain regions and, taken as a whole, provide a survey of whole brain functioning.

Alertness Alertness describes the degree of wakefulness and may range from fully awake and alert to comatose and nonresponsive. The degree of alertness may be stable or fluctuating.

Orientation Orientation is conventionally described in three spheres: person, place, and time. Orientation to person reflects an understanding of who one is and one's relationship to others. Orientation to time and place exists in multiple dimensions. If a patient is disoriented it is important to establish the degree. Is a patient aware of being in a hospital but not know which hospital? Does the patient believe it is a hotel instead of a hospital? Does the patient know the city in which the interview is being conducted? The date, day of the week, and time of day? The calendar year? If not, can the patient describe the season or distinguish morning from afternoon? It is common for hospitalized patients who are removed from normal environmental cues to be mildly disoriented to time.

Concentration Concentration describes the ability to sustain attention over time. Concentration is one of the cognitive functions most easily assessed simply by talking with a patient. Patients who forget the examiner's question, are distracted by extraneous stimuli, or lose track of what they are saying have impaired concentration. Concentration may be more formally tested in several ways. One of the most commonly taught and frequently misused tests is “serial sevens” in which a patient is asked to count backward from 100 by 7s. This is a valid test of concentration only if the person can comfortably perform the mental subtractions and if it is carried out for a substantial period of time. It is not intended to test the ability to perform calculations; the ability to concentrate and the ability to perform calculations should be evaluated separately. Alternative tests of concentration include counting backward by 3s, reciting the alphabet backward, spelling *world* backward, and naming the months of the year backward.

Memory Memory must be evaluated across the spectrum of immediate to remote. The brain substrates for long-term memory are different from those for immediate recall and short-term memory. This is illustrated clinically by patients with an anterograde amnesia such as Korsakoff's syndrome, in which long-term and immediate recall may be intact but recent memory is grossly impaired. As with concentration, much information about memory will be revealed in the course of the general interview. One test of immediate recall is to say (without inflection or verbal spacing) a series of numbers and have the patient repeat the series. A progressively longer sequence of numbers is presented, and both forward and backward recall are tested. Most adults can easily recall five or six numbers forward and three or four in reverse. Recent memory is for events several minutes to hours old and may be evaluated by giving patients the names of three or four unrelated objects and asking them to repeat them after 5 to 10 minutes. Remote memory describes events 2 or more years old. It is usually revealed in the course of obtaining patients' histories, although it may be necessary to confirm facts through collateral sources.

Calculations Calculations describes the ability to manipulate numbers mentally. Simple addition, subtraction, or multiplication questions may be used. Problems of money and change are often helpful with patients with limited educational background. For example, if a magazine costs $3.50 and you pay with a ten dollar bill, how much change should you be given? As noted above, the person should not be asked to perform serial subtractions to test calculating ability since it also requires concentration.

Fund Of Knowledge Fund of knowledge must be tailored to the unique circumstances and educational level of the individual. Patients are often asked to name presidents of the United States, starting with the incumbent and proceeding backward as far as can be remembered. This is not appropriate for everyone; recent immigrants to the United States may have difficulty with this even though they could give a detailed political history of their home country. Questions about current events, key geographical facts (what ocean lies between South America and Africa?), and sports may further help in the assessment.

Abstract Reasoning Abstract reasoning describes the ability to mentally shift back and forth between general concepts and specific examples. The capacity for abstract reasoning is usually not achieved before ages 12 to 13, and for some people is never achieved. The patient's use of jokes, metaphors, or

aphorisms during the interview often reveals this ability. Of all the frequently used ways to test abstract reasoning, asking proverb interpretation is probably the least useful. For example, a clinician might ask the patient, "What does it mean, when someone says, "People who live in glass houses shouldn't throw stones'?" A conventional response, one that is able to generalize from the specifics of the proverb to the generalization might be "Don't criticize others of what you are guilty yourself." A nonabstract response would address the concrete particulars without grasping the larger meaning, for example, "You would break the glass." (Some answers will be idiosyncratic and difficult to classify as either abstract or concrete: "The police would see you and would come to arrest you.")

One difficulty in using proverbs to assess abstract reasoning is that people tend to recite meanings learned over the years rather than reasoning through the proverb when it is given in the mental status examination. Indeed, interpreting an unfamiliar proverb can be difficult even for well-educated people whose abstract reasoning is unimpaired. In addition, proverbs tend to be culture bound, and their interpretation may be better evidence of cultural literacy than of the capacity to reason abstractly. (Consider, for example, the East African proverb, "You can't cover a horned animal with a canvas cloth." This means that "truth will eventually be revealed despite efforts to suppress it.") One alternative to proverb interpretation in assessing abstract reasoning is to ask for the similarity between two or more items, which really means asking to what conceptual abstraction do both belong. (A dog and a spider are both living things.) Asking for differences seldom gives useful information about abstract reasoning because the only plausible answers tend to describe concrete physical properties (e.g., "One has four legs, the other eight"). In another test the patient is given three objects, two of which are conceptually related, and asked which object does not belong (e.g., shirt, sock and hammer).

Insight This portion of the mental status examination describes patients' capacity to recognize and understand their own symptoms and illness. It does not measure the severity of illness. Patients with mild somatoform disorders may fail to recognize the emotional origins of their physical symptoms. On the other hand, some psychotic patients understand that their hallucinations are a symptom of a psychiatric disturbance that needs better control.

Judgment Observations about judgment in the mental status examination address two issues: can the person recognize prevailing social norms of behavior and comply, and will this person be able to cooperate with medical evaluation and treatment. Of all areas in the mental status examination, this is the least descriptive and most inferential. The psychiatrist must often draw from information in the history to supplement mental status findings. Some writers have advocated posing hypothetical situations to patients, asking, for example, "What would you do if you found a sealed, stamped, addressed envelope lying on the sidewalk?" Problems arise in using these kinds of data, particularly to the exclusion of other information. The presumed correct response to such scenarios is often obvious, and the answer may be very different from the patient's actual behavior. Moreover such questions often miss the complexity of variables shaping behavior and are simplistic in assuming a single correct response. An indigent homeless person who would open the envelope to see if there was money inside may be demonstrating good judgment in the context of his or her circumstances. Judgment may be more usefully assessed by observing the patient's behavior during the interview and by asking for elaboration on true incidents in the recent history—for example, "Why did you stop taking the medication?" or "Tell

me what you were thinking when you gave away your car keys and registration to a stranger. Does it seem like a good idea now? Would you do it again?” Some psychiatrists advocate describing intelligence in the mental status examination. This cannot be done with any validity or reliability without the use of standardized instruments, and even then it may be difficult to distinguish between intelligence and education. Rather than record an impressionistic hunch, the examiner will do better to present the data of the evaluation without interpretation. Areas that loosely correlate with intelligence are vocabulary (under *speech*) and fund of knowledge and abstract reasoning in the *sensorium*.

Alertness: Alert and awake throughout the interview

Orientation: Intact to person, place, and time

Concentration: Spelled *word* backward correctly; serial 7s performed correctly and without hesitation

Memory: Registration and recent memory (5 minutes) intact for 3/3 phrases (blue rose, 37, happiness); long-term memory appears intact as evidenced by his detailed recall of past events in the history.

Calculations: $6 \times 12 = 72$; \$2.00 – 65 cents = \$1.35

Fund of knowledge: Good. He knew presidents back to Carter. He said WWII started around 1940 and then spontaneously added, “Hitler and Normandy.” He knew that Einstein was responsible for the theory of relativity.

Abstract thinking: Somewhat concrete; similarities: apple/orange—“both fruits”; poem/statue—“both have form”; fly/tree—“both are nature, both are iridescent green, flies fly around crap, which is brown, the same color as tree bark”

Insight: Poor. The patient does not recognize the presence of any illness or that his behavior is dangerous, stating, “Maybe I have a very mild case of mania, but if I need to be here, then 90 percent of everyone in the world needs to be locked up.” He initially refused to take medication and repeatedly says he doesn't need to be “locked up,” that he can take care of his minor relationship problems as an outpatient. He calls his drinking “minimal” and doesn't realize that it precipitates dangerous, self-destructive behavior.

Judgment: Fair. He cooperates with staff even though he doesn't think he needs hospitalization because he fears that a history of involuntary commitment would make it difficult for him to realize his goal of becoming a teacher. He says that the next time he is angry with his boyfriend, he will “work it out,” and not try to kill himself.

TECHNIQUES FOR THE PSYCHIATRIC ASSESSMENT

The psychiatrist wants not only to ask the questions necessary for formulating a differential diagnosis, but also to establish rapport and create an atmosphere of confidence and trust. Relaxed and trustful patients are more likely to provide useful information than those who are nervous or on guard.

Time and Setting The initial psychiatric assessment usually lasts between 45 and 90 minutes, with the length of time agreed upon in advance. Sometimes additional time is necessary to complete the evaluation, in which case it is better to schedule an additional session. Extending the length of the first session unilaterally is a discourtesy to the patient whose time may be scheduled with other demands, and it risks fatigue for both parties. In addition seeing the patient at different times helps to determine more accurately which presenting features are purely situational and how they have changed with time.

The evaluation should be conducted in a comfortable room with pleasant lighting. While there is no reason to make the room impersonal, dramatic paintings, panoramic views, or expensive antiques may be distracting to a patient during a first visit. The psychiatrist should budget the full amount of time allotted for the interview and attempt to ensure that there are no interruptions during the session. Routine phone calls and messages should be intercepted by an answering machine or secretary. A comfortable waiting area should be provided for patients who arrive early. Many psychiatrists prefer to have the patient's and examiner's chairs of relatively equal size and height to minimize any sense of intimidation.

Interview The psychiatrist should have in mind the categories of information needed and their structural organization in the summary evaluation. However, it is seldom useful to proceed with a prescribed check-list of questions. Rather, the interview should be shaped as it progresses, with the psychiatrist's knowledge of psychopathology used to ask detailed or probing questions about significant issues as they emerge. It is often best to begin with a general, open-ended question (e.g., "How can I help you?" or "What brings you here today?") and to allow the patient to talk freely for several minutes before interposing further questions. However, the psychiatrist must keep in mind the information needed to formulate a diagnosis and treatment plan and be prepared to structure the interview more tightly if the patient appears to be vague and rambling. If a patient talks on with no pauses or natural endings, it may be necessary to interrupt and redirect. This can be done with courtesy and minimal disruption. For example, the psychiatrist might say, "Excuse me for interrupting, but I'd like to come back for a moment to the trouble you mentioned having had with sleep. How many hours of sleep did you get last night?"

Open-Ended and Closed-Ended Questions Open-ended questions ask the patient to speak spontaneously with relatively little structure or organization imposed by the examiner (e.g., "Tell me about your growing up"). Closed-ended questions on the other hand ask for factual answers to specific questions. (e.g., "How far did you go in school?") Open-ended questions are commonly associated with psychodynamic interviewing and closed-ended questions with phenomenologic-descriptive diagnostic interviewing; this is an unhelpful oversimplification. A skillful diagnostic interview uses both types of questions. It is often useful to begin the interview with broad open-ended questions and to become more closed-ended and directive as the interview progresses.

There are a number of advantages in starting with open-ended questions: the content is less limited by the examiner's preconceptions, disorders of thought form are more likely to be revealed in spontaneous speech than in two- or three-word answers, and emotional responses may be more obvious. In addition, many patients prefer to tell their stories with their own words and emphases without interruption. Other patients, such as those who are psychotic, depressed, or paranoid, may need more structured questions. Closed-ended questions are particularly useful in clarifying information, in gathering factual data efficiently, and in describing the absence of key symptoms. Patients are unlikely to spontaneously describe what does not exist.

Supportive and Obstructive 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 (correctly or erroneously) conveys information to the patient. Interventions may be classified as supportive or obstructive depending on the extent to which they increase the flow of information and enhance or diminish rapport. Interventions classified as supportive include

Encouragement. Patient: I am not very good at putting things into words.

Doctor: I think you have described the situation very well.

Reassurance. Doctor: I can understand how those experiences must have frightened you, but I think it is very likely they'll respond to treatment.

Acknowledging emotion. Doctor: Even now it brings tears to your eyes when you talk about your mother.

Nonverbal communication. Body posture and facial expression that convey interest, concern, and attentiveness.

Interventions classified as obstructive include

Compound questions. Doctor: Have you experienced any change in your appetite and sleeping?

Judgmental questions. Doctor: How do you think your wife felt when she found out about your affair?

Why questions. Doctor: Why do you feel anxious when you go outside?

Not following the patient's lead. Patient: I have trouble sleeping through the night.

Doctor: Any change in appetite?

Patient: I keep waking up out of nightmares about my daughter.

Doctor: Do you have less energy than usual?

Minimization or dismissal. Patient: I'm not able to keep my checkbook balanced the way I need to.

Doctor: Oh, I wouldn't worry about it. Lots of people don't even try.

Premature advice. Patient: Work is almost unbearable. My supervisor watches me like a hawk and criticizes the tiniest little mistake I make.

Doctor: Why not write her a memo and outline your grievances?”

Nonverbal communication. Yawning, checking one's watch. Patients can often detect an interviewer's inattention by the *absence* of facial expression or body movement.

Psychiatric interviewing is a complex, multifaceted task that is shaped by the personalities and circumstances of the interview. The concept of supportive and obstructive interventions has broad, general use but cannot be applied rigidly. There are circumstances in which an intervention that would be obstructive with other patients may be helpful or even necessary. For example, although it is usually most helpful to follow the patient's lead, the psychiatrist interviewing a hypochondriasis patient or a depressed patient with somatic concerns may need to ignore or interrupt perseveration about physical symptoms and redirect the interview to other topics. In addition, at times the psychiatrist may appropriately ask patients how their misdeeds are perceived by others (a judgmental question) to test empathy.

Interpreting Behavior During an Initial Diagnostic Interview The psychoanalytic techniques of interpretation and clarification should be used minimally if at all during an initial diagnostic assessment. The psychiatrist is unlikely to have enough information to make accurate interpretations. Moreover, the context of a trusting long-term relationship that facilitates acceptance of interpretations will be lacking. Patients who arrive late for the session may well be manifesting anxiety or ambivalence or may equally well have been delayed by circumstances beyond their control. Rather than interpreting the lateness, the psychiatrist would do better to express regret at the late start and offer sympathetic understanding to the patient for the problems causing the lateness. Separately, the psychiatrist can ask whether the patient was nervous or had mixed feelings about coming for the evaluation.

An exception to the rule against interpretations in the first session is the patient for whom a psychodynamic psychotherapy may be recommended. The psychiatrist may then want to evaluate the patient's response to a gentle test probe to assess suitability for psychodynamic work.

> A 28-year-old woman who asked to start therapy with a psychoanalytic psychiatrist missed her first session. At the second session she reported that she simply forgot the appointment. The psychiatrist asks, “Is it possible that you let yourself forget on purpose?”
>
> The woman laughs and says, “Well to tell you the truth, it's really my boyfriend whose been pushing me to start therapy; I'm not so sure. Do you think it's a good idea?”

Recording and Note Taking Electronic recording of sessions is seldom necessary and is often detrimental. Patients become self-conscious and guarded when their every word is being recorded. Many patients are concerned about the uses to which the recordings will be put and are rightfully concerned about potential abuses. Few patients are likely to feel comfortable knowing that their sometimes critical comments about another person or intimate discussion of private issues might be heard by anyone other than the evaluating psychiatrist. Recordings must never be made without the patient's knowledge and consent.

Psychiatrists vary in the extent to which handwritten notes are taken during a session. Some examiners take no notes at all during the evaluation and then write a summary after the patient has gone. They argue that note taking is a distraction to both psychiatrist and patient, that it becomes a barrier to subtle emotional observation and understanding, and that some patients become preoccupied by what is being written down, thus contaminating what they say. By not taking notes during the interview they train themselves to remember better the details of the session. They point out that when they do rely on notes they are unlikely to remember anything that was not written down.

Other psychiatrists take almost continuous notes. They believe it is possible to do so unobtrusively and that it provides subtle reassurance to patients about the seriousness with which the examiner is taking their statements. The result, they believe, is a more accurate record, not vulnerable to the distortions of memory.

Still other psychiatrists take notes selectively, when they believe that accurate and detailed documentation is necessary (e.g., a complicated history of previous medication treatments and variable responses). Individual psychiatrists develop techniques that work well for them, but they must remain mindful of the impact their individual decisions have on the ability to get useable information. Flexibility and common sense must not be lost. It would be destructively unfeeling for a psychiatrist to continue note taking in the middle of an intense emotional moment with the patient sobbing. Requests by the patient that notes not be taken may be explored but should always be respected.

Whether or not notes are taken during the session, psychiatrists have a medical and legal obligation to maintain a written record of every patient encounter. Such records document that the encounter occurred and that the assessment was complete. The record contains the historical and mental status data on which a diagnosis and treatment recommendations are based. The physician describes in detail all treatment recommendations and other advice given. (Psychiatrists should also routinely compile written descriptions of all telephone exchanges with patients. This is particularly important if the telephone

exchange includes a change in treatment.) It is helpful to keep in mind the legal rule of thumb: "If it isn't written down, it didn't happen."

Special Problems in Interviewing

PSYCHOTIC PATIENTS Patients with psychotic symptoms have difficulty thinking clearly and reasoning logically. Their ability to concentrate may be impaired, and they may be distracted by hallucinations and delusional beliefs. Psychotic patients are often frightened and may be quite guarded. Quite often, the evaluation of a patient with psychotic symptoms needs to be more focused and structured than that of other patients. Open-ended questions and long periods of silence are apt to be disorganizing. Short questions are easier to follow than long ones. Questions calling for abstract responses or hypothetical conjectures may be unanswerable.

For patients with hallucinations, the full phenomenology of the hallucination should be explored. The patient is asked to describe the sensory misperception as fully as possible. For auditory hallucinations this includes content, volume, clarity, and circumstances; for visual hallucinations, this includes content, intensity, the situations in which they occur, and the patient's response. The evaluator should distinguish between true hallucinations on the one hand and illusions, hypnagogic and hypnopompic hallucinations, and vivid imaginings on the other. Hallucinations are perceived as real sensory stimuli and should not be dismissed as fanciful; however the psychiatrist should ask questions about their fixity and the patient's level of insight. "Does it ever seem that the voices are coming from your own thoughts?" or "What do you think is causing the voices?"

Delusions by definition are fixed, false beliefs. Delusional patients often come to psychiatric evaluation having had their beliefs dismissed or belittled by friends and family. They will be on guard for similar reactions from the examiner. It is possible to ask questions about delusions without revealing belief or disbelief (e.g., "Does it seem that people are intent on hurting you?" rather than, "Is there a plot to hurt you?"). Careless use of psychiatric jargon should be avoided, particularly in evaluating delusions. Words such as *grandiose, paranoid*, and indeed the word *delusion* itself will seem harsh and judgmental and are unlikely to be helpful in eliciting information. Many psychiatrists have found that patients can speak more freely when asked to talk about the accompanying emotions rather than the belief itself ("It must be frightening to think there are people you don't know who are plotting against you.") Although the psychiatrist does not attempt to reason them away, a gentle probe may determine how tenaciously the beliefs are held ("Do you ever wonder whether those things might not be true?").

Patients with paranoid delusions (and patients with high levels of nondelusional suspiciousness) are best evaluated with a respectful, but somewhat distant, formality and with scrupulous honesty. Efforts to reassure or ingratiate often increase suspicion. The psychiatrist must keep in mind the possibility of being incorporated into a delusional belief and should ask about it directly ("Are you concerned that I might try to hurt you?").

Disorders of thought form can seriously impair effective communications. The evaluating psychiatrist

should note formal thought disorders while minimizing their adverse impact on the interview. When derailment is evident, the psychiatrist typically proceeds with questions calling for short responses. For a patient experiencing thought-blocking, the psychiatrist needs to repeat questions, remind the patient of what was already said, and in general provide an organization for thinking that the patient is unable to provide.

DEPRESSED AND POTENTIALLY SUICIDAL PATIENTS Severely depressed patients may also have difficulty concentrating, thinking clearly, and speaking spontaneously. The intensity of mood disturbance can seem all consuming and may well lead to distortions in thinking and perception. Some depressed patients will have psychotic symptoms in addition to cognitive difficulties. The psychiatrist evaluating a depressed patient may need to be more forceful and directive than usual. It will sometimes seem that the examiner must provide all the emotional and intellectual energy for both participants. Although depressed patients should not be badgered, long silences are seldom useful, and the examiner may need to repeat questions more than once. Ruminative patients—for example, those who continually repeat how worthless or guilty they are—will need to be interrupted and redirected.

All patients must be asked about suicidal thoughts. Depressed patients may need to be questioned more fully. A thorough assessment of suicide potential addresses intent, plans, means, and perceived consequences as well as history of attempts and family history of suicide. Many patients will mention their thoughts of suicide spontaneously. If not, the examiner can begin with a somewhat general question such as, “Do you ever have thoughts of hurting yourself?” or “Does it ever seem that life isn't worth living?” These can then be followed up with more specific questions. The examiner must feel comfortable enough to ask simple, straightforward, noneuphemistic questions. Asking about suicide does not increase the risk. The psychiatrist is not suggesting a course of action the patient has not already contemplated. Specific, detailed questions are essential for prevention.

Intent The examiner must determine the seriousness of the wish to die. Some patients report that they wish they were dead but would never intentionally do anything to take their own lives. This level of intent is often referred to as *passive suicidal ideation*. Other patients express greater degrees of determination. Near the other end of the spectrum of intent is the patient who says, “I've decided I have to kill myself and nothing you can say or do will change that.” At the most extreme level of determination are the patients most difficult to help, those who tell no one about their suicidal plans and proceed in a deliberate, systematic manner. It is also useful to ask about restraining influences, both internal and external (e.g., “Do you worry that you might not be able to resist those impulses?” or “How have you been able to keep from hurting yourself so far?”). Patients with auditory hallucinations commanding then to kill themselves often describe the hallucinations as irresistible despite any real desire to die.

Plans Patients with well-formulated plans are generally at greater risk than patients who don't know what they would do, but the method of suicide is not always a reliable indication of the risk. Even though some actions such as jumping or shooting are much more likely to be fatal than others, patients make mistakes. A pill overdose taken at the time a spouse is expected to arrive home may become deadly if the spouse is delayed in traffic. The psychiatrist should also ask about preparatory actions such

as giving away goods or putting one's estate in order.

Means Asking patients about the intended means of suicide is helpful in two ways. First it clarifies the urgency of the situation; persons wanting to shoot themselves who have a loaded gun at home are more dangerous than those who have no idea where to find a gun. Second, the understanding of intent is sharpened by knowing whether a patient has thought through the steps necessary to carry out the action.

Perceived Consequences Patients who see something desirable resulting from their deaths are at increased risk for suicide. A reunion fantasy, the belief that a person will be reunited with a deceased loved one, may be a powerful motivating force toward suicide. On the other hand, some potentially suicidal patients are restrained by what they see as negative consequences (e.g., “My children need me too much; they'd never be able to get along without me,” or “I couldn't hurt myself. My parents would never get over their grief.”). The psychiatric history and the family history for all patients, even those not currently suicidal, should mention any previous suicide attempt or suicides by family members. Both circumstances are recognized to increase the current risk, even if previous attempts were thought to be superficial.

At times treatment must take precedence over evaluation. In rare circumstances the threat of suicide is so imminent that immediate action must be taken to hospitalize the patient. Even during a first evaluation session, the psychiatrist must be prepared to make whatever professional response is necessary to safeguard the well-being of the patient.

AGITATED AND POTENTIALLY VIOLENT PATIENTS Whether in a private office or a psychiatric emergency room, psychiatrists sometimes find themselves interviewing potentially violent patients. In these circumstances, the task is twofold: to conduct an assessment but also to contain behavior and limit the potential for harm.

Most unpremeditated violence is preceded by a prodrome of accelerating psychomotor agitation. The patient may begin pacing and pounding the fist in a hand. Speech may become loud, abusive, obscene, and threatening. The temporal arteries may begin to throb. Researchers and clinicians in emergency psychiatry suggest that the prodrome may last from 30 to 60 minutes before erupting into physical violence. Thus the psychiatric evaluator has both early signals of impending violence and a period of time in which the agitation may be quieted.

Several steps can be taken to minimize the agitation and potential risk. The interview should be conducted in a quiet, nonstimulating environment. There should be enough space for the comfort of both patient and psychiatrist, with no physical barrier to leaving the examination room for either of them. During the interview, the psychiatrist should avoid any behavior that could be misconstrued as menacing: standing over the patient, staring, or touching.

The psychiatrist must ask the questions necessary to complete an adequate evaluation but must attempt not to be provocative. It is certainly appropriate to allow the patient to drink water, use a bathroom, and,

for extended evaluations in an emergency room, eat food. However, these should never be offered as bargaining chips (“I'll let you get a drink of water if you'll tell me what happened just before the police brought you here.”) The examiner must also avoid promising outcome in exchange for cooperation (“If you'll just talk with me for another half hour, I'll make sure you don't have to go into the hospital.”)

The psychiatrist should ask whether the patient is carrying weapons and may ask the patient to leave the weapon with a guard or in a holding area. The psychiatrist should not request that patient hand over any weapons. Dangerous mishaps can occur during the transfer; moreover, the sudden shift in power created by an armed psychiatrist may feel extremely threatening to paranoid patients. If the patient's agitation continues to increase, the psychiatrist may need to terminate the interview. Depending on the setting, assistance from security personnel, physical, or chemical restraints may be appropriate. The physician's own subjective sense of comfort or fear should be heeded. A frightened, intimidated examiner may be incapable of an accurate professional evaluation.

PATIENTS FROM DIFFERENT CULTURES AND BACKGROUNDS Differences in race, nationality, and religion and other significant cultural differences between patient and interviewer can impair communication and lead to misunderstandings. Despite its widespread use throughout the world, the possible cultural biases of DSM-IV are still being debated; for example, the distinctions between mood disorders and somatoform disorders appear less valid in some countries than in the United States.

In addition, it may be difficult for a culturally naive psychiatrist to evaluate symptoms that are relative rather than absolute. There is usually no difficulty in documenting the presence of auditory hallucinations regardless of cultural differences. However, assessing whether or not a delusion is “bizarre” (as required by DSM-IV for delusional disorder) is more difficult because “bizarre” has meaning only in reference to cultural norms. The belief by East Africans in the direct intervention of ancestral spirits in the day-to-day life of individuals is commonplace. The chief executive officer of an American corporation who announces that he will divest the company of two subsidiaries because of signals he received that morning from ancestral spirits will be thought exceedingly bizarre by colleagues and shareholders. Personality disorders, whose criteria are preponderantly relative rather than absolute (e.g., “shows arrogant, haughty behaviors or attitudes”), are notoriously difficult to diagnose cross-culturally.

Apart from diagnostic categories, the vocabulary used to describe emotional distress varies from culture to culture. European-Americans commonly describe symptoms in terms of named emotions (“I've been feeling anxious and depressed all week”). Hispanic-Americans are more likely to describe physical symptoms (“I've had a headache all week, and I'm so tired I can hardly move”). Sometimes symptoms that are commonplace within a culture are unheard of to outsiders. Residents of Anglophonic countries in East and West Africa often describe the sensation of a snake crawling under their skin, moving from one part of the body to another. This appears to be a symptom of general emotional distress without particular diagnostic significance. Heard by a Western physician, the symptom may be misinterpreted as a somatic delusion or ignored altogether, because it does not register in the examiner's conceptual understanding of disorders.

Additional problems are encountered when doctor and patient speak different languages. When an interpreter is needed, the person should be a disinterested third party, unknown to the patient. Using family or friends to translate inevitably invites distortions in what the patient is said to report. Translators must be instructed to translate verbatim what the patient says—a difficult task for even the most experienced professional translators. Some words and expressions are simply untranslatable. It may be impossible to convey a formal thought disorder through translation.

An additional difficulty may arise in establishing rapport between doctor and patient of different ethnic or cultural groups. The use of honorifics, the extent of direct eye contact considered appropriate, or whether it is acceptable for men and women to shake hands, all vary considerably among different groups. Patients from minority groups may be quite guarded in speaking with a doctor from the majority group. Some groups such as traditional Chinese-Americans strongly believe that family problems should not be discussed outside the family, including with physicians. The evaluating psychiatrist must proceed with humility and respect. Rather than offer reassurances of understanding and acceptance, it is usually better to ask, “Have I understood this in the way you meant it?”

SEDUCTIVE PATIENTS The warmth, openness, acceptance, and understanding that are helpful to most psychiatric interviews may engender feelings of romantic longing in some patients, especially (but not exclusively) those who are lonely and socially isolated. Other patients may have flirtatious and seductive ways as their habitual style of relating with other people. Seductiveness may be manifested in a patient's dress, behavior, and in what is said. It runs the gamut from gentle suggestion to explicit proposition. A young man may sit with his legs spread wide apart, a young woman may wear a low-cut revealing dress, or a middle-aged woman, when shaking hands, may hold the psychiatrist's hand a few seconds longer than appropriate for the situation.

Of course sex is not the only enticement with which psychiatrists can be seduced. Patients may offer insider information for profitable trading in the stock market, promise an introduction to a movie star friend, or suggest that they will dedicate their next novel to the psychiatrist. While it is easy to understand that some offers by patients such as the possibility of a sexual involvement cannot be acted on without considerable harm to the patient, others may seem more innocuous. However, because they nearly always introduce a different agenda into the therapy than that originally contracted for and because they create additional, more ambiguous levels of obligation between therapist and patient, any psychiatric work is inevitably contaminated, and the ability to help the patient is compromised. Consequently, gaining material or social benefit from the patient other than the agreed upon fee is unethical.

Whether to offers of sex, money, or celebrity, the psychiatrist's response is the same. In the course of ongoing psychotherapy and in the context of an established relationship, seductive behavior is discussed and examined in an effort to understand its meaning. Is it for example, a way of distancing, of gaining control, or of compensating for feelings of vulnerability and inferiority? To what extent are the feelings being expressed by the patient part of the transference? The psychiatrist should make it clear that what is being offered will not be accepted, in a way that preserves good rapport and does not unnecessarily

assault the patient's self-esteem.

Seductive behavior during an initial psychiatric assessment must be handled somewhat differently. When the behavior is mild and indirect, it may be best to ignore it; commenting on a woman's exposed cleavage only makes it clear that the psychiatrist is picking up sexual cues and is most unlikely to facilitate the interview. More-explicit propositions call for more-direct responses and may afford the psychiatrist the chance to explain the nature of the therapeutic relationship and the need to establish boundaries. The psychiatrist should also make clear that it is the violation of those boundaries that is being rejected and not the patient. For example, to the patient who offers a celebrity introduction, the interviewer might reply, “That's very nice of you to propose, but I think I will best be able to help you if we pretty much stick to the issues that brought you in to see me.”

PATIENTS WHO LIE A fundamental stance in psychiatric interviewing is recognizing that what is being heard may not be literal truth. The unreliability of memory and the vagaries of psychopathology through which a patient's narrative is processed will distort and falsify. The interviewer understands that what is historically untrue may nevertheless be emotionally true and is therefore a meaningful part of the diagnostic assessment or psychotherapy.

At times patients lie consciously with the explicit intent of deceiving the therapist. The purpose may be secondary gain (e.g., exemption from jury duty, a supply of psychoactive drugs, a leave of absence from graduate school), in which case the person is malingering. Malingering is not a mental disorder in DSM-IV. More rarely a patient will explicitly lie not for any obvious external advantage but simply for whatever psychological benefit is conferred by assuming the sick role, in which case the person may have a factitious disorder, which is a DSM-IV mental disorder.

Because psychiatrists do not have recourse to biologic markers or other external validating criteria, the patient's report must be accepted as an honest statement of experience. There is no way to establish whether a person is experiencing auditory hallucinations other than through self-report. Nevertheless, an experienced clinician may detect subtle discrepancies, internal inconsistencies, or suspiciously atypical symptoms; these can certainly be queried without necessarily assuming that the patient is lying.

> A 29-year-old woman describes almost unremitting migraine headaches and is asking for narcotic pain medication.
>
> Patient: I really need your help. The pain is unbearable. I can't do anything anymore. I just want to lie in bed in a dark room with the cover pulled over my head.
>
> Doctor: That does sound miserable. But I'm struck by the fact that you obviously care about your appearance and have given some time and attention to your hair, makeup, and the way you are dressed. Was that despite the pain you have been describing?

Of course the examiner is more likely to be deceived during the initial diagnostic assessment than in an

ongoing psychotherapy in which the therapist has much more knowledge of a patient's background, thinking, and functioning over time. It may be difficult to catch a practiced liar in an initial session. Arguably the interviewer should not try. Being lied to angers most people, certainly no less psychiatrists who must depend on trust to perform their work. However, believing a patient's lies is not a professional failure. Psychiatrists are trained to detect, understand, and treat psychopathology, not to function as lie detectors. While a certain level of suspicion is essential in the practice of psychiatry, the clinician determined never to be taken in by deceitful patients will approach patients with such exaggerated suspiciousness that therapeutic work is not possible.

Finally, not all patients' untruths are conscious lies. Patients with somotoform disorders such as conversion disorder or pain disorder are presumably unaware of the emotional bases of their physical complaints. In describing their somatic symptoms they are stating a psychological reality, not attempting to deceive the interviewer.

Empathy A diagnostic interview often provides considerable relief to patients. Puzzling and sometimes frightening symptoms are framed in the context of medical understanding. Bizarre experiences can be rationally understood and intelligently organized in meaningful ways that allow us to make informed predictions about treatment response and recovery. Of equal importance to an intellectual understanding is our capacity to understand emotionally the experiences of our patients.

Empathy is an essential characteristic of psychiatrists, but it is not a universal human capacity. An incapacity for normal understanding of what other people are feeling appears to be central to the disturbance of certain personality disorders such as antisocial and narcissistic personality disorders. While empathy can probably not be created, it can be focused and deepened through training, observation, and self-reflection. It manifests in clinical work in a variety of ways. An empathic psychiatrist may anticipate what is felt before it is spoken and can often help patients articulate what they are feeling. Nonverbal cues such as body posture and facial expression are noted. Patients' reactions to the psychiatrist can be understood and clarified.

Patients sometimes say, “How can you understand me if you haven't gone through what I'm going through?,” but clinical psychiatry is predicated on the belief that it is not necessary to have other people's literal experiences to understand them. The shared experience of being human is often enough. Whether in an initial diagnostic setting or in an ongoing therapy, patients draw comfort from knowing that we are not mystified by their suffering.

SUGGESTED CROSS-REFERENCES

Section 9.3 deals with the typical signs and symptoms of psychiatric illness, Section 9.5 deals with neuropsychological and intellectual assessment of adults, and Section 9.8 deals with psychiatric rating scales. Similarly, Chapter 10, on the clinical manifestations of psychiatric disorders, is an essential correlate to interviewing and examining the patient. More-specialized focus is provided in Section 2.1, which deals with the clinical assessment and approach to diagnosis in neuropsychiatry. Section 3.1 on

perception and cognition and Section 3.4 on the biology of memory amplify points made in this section. Section 29.1 includes more-detailed information on suicide, and Section 29.2 includes information on other psychiatric emergencies. Additional relevant information is found in Chapter 45, which deals with mood disorders and suicide in children and adolescents. Taking a developmental history implies familiarity with the aspects of normal and abnormal development; readers may find the following sections of special interest: Section 6.2 deals with Erik H. Erikson and his ideas about child and adult development; Chapter 32 deals extensively with normal development in children and adolescents; adult development is covered at great length in Chapter 50; and normal aging is the focus of Section 51.2c.

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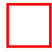

Table 7.1-1 Psychiatric History and Mental Status Examination

I. Identification
II. Chief Complaint
III. History of the Present Illness
IV. Past Psychiatric History
V. Medical History
VI. Family History
VII. Personal History (including developmental history)
   A. Early childhood (through age 3)
      1. Developmental milestone
      2. Intrafamilial relationships
   B. Middle childhood (ages 3 to 11)
      1. Friends
      2. School
   C. Adolescence
      1. Puberty
      2. Psychosexual history
      3. Dating and peer relationships
      4. School performance
      5. Drug and alcohol use
   D. Early adulthood
      1. Marital and other adult relationships
      2. Work history
      3. Recreational and vocational pursuits
      4. Military history
      5. Prison history
   E. Middle and older adulthood
      1. Changing family constellation
      2. Retirement
      3. Losses
      4. Aging
VIII. Mental Status Examination
   A. Appearance
   B. Speech
   C. Emotional expression (includes mood and affect)
      1. Subjective
      2. Objective
   D. Thinking and perception
      1. Form
      2. Content
      3. Perception
   E. Sensorium
      1. Alertness
      2. Orientation
         a. Person
         b. Place
         c. Time

b. Place
c. Time
3. Concentration
4. Memory
a. Immediate
b. Recent
c. Remote
5. Calculations
6. Fund of knowledge
7. Abstract reasoning
F. Insight
G. Judgment

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Table 7.1-2 Formal Thought Disorders

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

Example: A 79-year-old woman is describing her headaches to her doctor. "They usually start in the morning. I'll wake up at 6 or 6:30, and then by the time I have my coffee . . . well sometimes I'll have tea. I like it with lemon and just a bit of sugar . . . or honey sometimes. I always take milk with coffee. And like I was saying, after coffee I may turn on the TV for a half hour or so. Well, unless there's something really good. If I'm watching the news, I may not even notice the headaches, but by lunch they're so bad I have to lie down."

Clang association. Thoughts are associated by the sound of words rather than their meaning, for example, though rhyming or assonance.

Example: A 31-year-old man in the manic phase of bipolar disorder was asked if he had any trouble sleeping. He replied, "I never have trouble sleeping. I never have trouble peeping. I never have trouble pooping."

Derailment. (Synonymous with *loose associations*) There is a breakdown in both the logical connection between ideas and the overall sense of goal-directedness. The words make sentences, but the sentences don't make sense.

Example: A 19-year-old man with a first psychotic episode describes the week at home before coming into the hospital. "I . . . I watched TV, but the newspaper didn't come. I . . . David is at school, too. Sometimes it's better to be alone, you know, to save for a rainy day."

Flight of ideas. A succession of multiple associations, so that thought seems to move abruptly from idea to idea. Often (but not invariably) expressed through rapid, pressured speech.

Example: A 37-year-old man who is in the middle of a manic episode is speaking with great rapidity: "I just got back from New York. Call it the Big Apple, but it's rotten to the core. Nobody can take me. I could beat up my father. He was tough, a salesman. He sold his soul for a pig in a poke."

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

Example: A 25-year-old man with a diagnosis of chronic undifferentiated schizophrenia described his activities during a pass from a psychiatric hospital: "We went to the park. It was hot, but not too hot. It was burging."

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

not. It was burging."

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

Example: A psychiatrist is evaluating an 86-year-old woman in a nursing home.

Psychiatrist: Do you know what day it is?

Woman: Yes, Tuesday.

Psychiatrist: And where are we now?

Woman: Tuesday.

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

Example: A 40-year-old man with depression is being evaluated by a psychiatrist.

Psychiatrist: Have you had trouble sleeping through the night lately?

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

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

Example: A psychiatrist is interviewing a 55-year-old man.

Psychiatrist: Have you been drinking more than usual in the last couple of months?

Patient: Not really. I've always been a pretty big drinker. . . could hold my liquor pretty well.

Psychiatrist: How much would you drink in a normal day?

Patient: Maybe a pint. Two pints sometimes. . . no [pause]

Psychiatrist: What?

Patient: I forgot. What were we talking about? What did you ask me?

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