

RUN, RUN, RUN! BECAUSE
THERE IS A MAN, WHO HAS
GONE **MAD**!!!!

HE CALLS HIMSELF THE WHITE
PHAR-LAP HORSE,
WHO IS GREATER THAN THE
FIRST BLACK PHAR-LAP!
AND HE SAYS, THAT HE IS
THE 3. BLACK HORSE TOO!
THE JUDGE-LIKE BIRD,
WITH BLACK CAP AND
YELLOW FEETS AND BEAK!

POPE LIKE CAP ON HIS
HEAD? CERTAINLY HE
HAS GONE **MAD**!

Psychiatric assessment, symptoms and signs
S. Pridmore

TAKE YOUR CAMERAS AND
PHOTOS, AND LOOK WHAT
HE DID IN THE CHURCH

Psychiatric assessment, symptoms and signs

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**Dedicated to
Mary
Emma and William**

Psychiatric assessment, symptoms and signs

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Introduction to psychiatry

Introduction

The aim is to provide a structure and some practical advice for clinicians who conduct diagnostic interviews in psychiatry and related fields.

The psychiatric assessment is usually conducted over about one hour. A conclusion may not be reached at single sitting, but the process is essentially a series of cross-sectional events. In this book, some examples are given which arose in the course of assessment/treatment of patients (sometimes years).

When psychopathology is possibly present, a psychiatric assessment is conducted, and based on any findings, a diagnosis and a management plan is formulated. An appropriate diagnosis and management plan is the first step and foundation on which future management is built.

In addition, the initial psychiatric assessment has therapeutic potential. At this point the patient will be at her/his most distressed, vulnerable, and even suspicious. A respectful but confident manner displayed by the diagnostic interviewer may have immediate and long-term influences on the ability of the patient to participate positively in management.

The initial psychiatric assessment is limited insofar as it is a single, cross-sectional sample, like a histological slide. Accordingly, we extend our knowledge of the case by obtaining information from others (family, other clinical staff), taking a thorough personal and personality history, and reassessment of the patient.

There is only one first interview between a patient and a particular clinician. That interview changes things. At future interviews the patient will not be as apprehensive, the signs and symptoms will not be as crisp and the clinician will not be as open to the range of possibilities.

Psychiatry is complex and evolving. An early task is to know what is and what is not a psychiatric problem.

Psychiatry and mental disorder

Psychiatry is a specialized field of medicine concerned with prevention, diagnosis, treatment and research of mental disorders. Mental disorders are behavioral or psychological syndromes that are associated with distress or

disability (impairment in functioning).

It is important that people experiencing normal reactions are not classified as suffering from a mental disorder. Conditions that may resemble disorders appear in circumstances of loss. If a child dies (for example) the parents will suffer great sadness and may not be able to function in their usual way for some time. This is a normal reaction.

It is also important that eccentricity and religious or unpopular political beliefs are not taken to be mental disorders. As recently as a decade ago, in some parts of the world people with social problems, particularly loneliness and homelessness, were offered care in psychiatric hospitals. Unless their problems have a psychiatric underpinning, such people no longer offered such accommodation and have correctly become the responsibility of other services.

Homosexuality and unusual sexual practices rate should be mentioned. If these bring no distress to the individual involved, they are not regarded as mental disorders. If they do bring distress the term mental disorder can be applied. If sexual or any other behavior (including domestic violence) brings distress to victims, police and social workers should be involved.

The biopsychosocial model

The biopsychosocial model (Engel, 1962) is useful in understanding of the probable causes and best current management of many mental disorders. (This model can be usefully applied to patients with any disorder, for example, back pain is sometimes treated surgically without due consideration of broader and often most important etiological aspects of the case.)

The term biopsychosocial is made up of two part-words and one complete word.

‘Bio’ refers to the biological (physical) parts of the individual. This means all of the organs of the individual. In psychiatry, the brain is most commonly the organ of interest. This is demonstrated when a person suffers frontal lobe damage - after the injury there may be lack of energy and interest, neglect of personal hygiene, use of bad language and violent outbursts.

When macroscopic brain changes are present, the term ‘organic mental disorder’ is applied. However, this term is becoming antique. Physical brain structures changes at the synaptic and molecular levels are constantly being demonstrated in

psychiatric disorders. These are, of course, organic changes, albeit of microscopic and submicroscopic dimensions.

The function of other organs of the body also deserve consideration, as distant pathology may lead to dysfunction of brain tissue. The thyroid gland is an example; both over-activity and under-activity may result in severe depression.

Genetic contributions have been demonstrated for most mental disorders, emphasizing the importance of biological factors.

Physical agents such as drugs may be the cause mental disorders. Examples include medical drugs such as prednisolone, which may produce mania, and propranolol, which may produce depression. Non-medical drugs such as cocaine and alcohol may result in severe mental disorders, ranging from transient psychosis to dementia.

Physical treatments for mental disorders include psychiatric drugs, electroconvulsive therapy (ECT), and transcranial magnetic therapy (TMS) all influence gene expression and thereby modify intracellular and synaptic structure and function. Other physical treatments such as and deep brain stimulation (DBS) and psychosurgery, while not clearly acting on genetic systems, may also have profound beneficial effect.

‘Psycho’ in biopsychosocial refers to the psychological aspects of the individual. Various factors are considered, including the individual’s personality and circumstances. Personality can be taken to mean the psychological composition (strengths, weaknesses and other psychological features) of the individual. Events (both recent and past) may be of importance to the individual. We know that loss can bring psychological distress (or psychological pain). In some individuals, but not all, severe loss (of a child, for example) may be associated with the onset of a mental disorder. Those who develop a mental disorder following loss may have a constitutional (often genetic) vulnerability. Complicating the picture, psychological experiences may result in physical changes in the brain. [The brains of rats that have been exposed to learning situations have heavier and thicker cortices than those which have not had those experiences (Greenough, 1985) and hippocampal atrophy occurs in humans following traumatic events (Bremner, 1999).]

Psychological techniques may be the sole treatment of some mental disorders and are important to some degree in the treatment of all mental disorders. Psychological treatments include counseling, behavioral therapy and psychotherapy. There are many forms. They all include regular meetings between the patient and a therapist, usually over a period of months or even years.

‘Social’ refers to the social aspects of the life of the individual. The social environment is important in the way we all think, feel and behave. It is well known that having a spectator crowd cheering a team on can influence the performance. In a community where children are highly valued, it can be expected that the loss of a child will be deeply distressing to the parents. However, in such a community the support and sympathy of others can help to ease the pain of bereaved parents. The lower importance placed on female children in some cultures has been reflected in differences in thinking, feeling and behavior between the sexes.

Social factors are used in treatment, most clearly in group therapy. In this form of therapy a group of patients comes together with a therapist to talk about and explore their problems. Many elements are important in such therapy, including gaining confidence in dealing with groups of people, the experience of acceptance by a group and the beneficial effect of social support and encouragement.

Social factors also operate when the family is involved in the treatment and rehabilitation of a patient with a mental disorder. Because of the power of social factors, families and others (such as teachers) are involved whenever possible.

Classification and diagnosis

Large, disorganized bodies of information are difficult to understand, describe and discuss with other people. Classification, where facts are put into certain categories or boxes, makes dealing with complicated information a bit easier.

The categories of disease are the diagnoses. A diagnosis is reached after a careful history has been taken and the patient has been examined. Special investigations may prove the diagnosis, as for example in gout. But for some diagnoses, such as schizophrenia, there are, as yet, no confirmatory tests.

In other branches of medicine there may be a host of physical signs—fever, swelling, tenderness, erythema, tremor, altered muscle tone—which

usually assist a great deal in forming the diagnosis. In mental disorders, the physical signs—loss of affect, posturing, echopraxia - can also influence the diagnosis, but they occur less commonly, are more subtle and, in general, are less useful.

In psychiatry, the history may contain characteristic features which may be helpful. For example, when there are delusions (false beliefs) present, the patient who believes he is guilty of a serious crime is probably suffering a depressive disorder, while the patient who believes others are guilty of serious crimes is probably suffering a paranoid disorder.

In all forms of medicine, the clinical diagnosis is based on a set of signs and symptoms, which regularly occur together. Most diagnoses carry etiological information, as in post-traumatic stress disorder (PTSD), or prognostic information (such as in Huntington disease).

The diagnosis may sometimes carry pathophysiological information, as in phenylketonuria, but as occurs in cardiology, where a complete understanding of arrhythmias is lacking, in psychiatry, the exact pathophysiology of many disorders remains to be determined.

Around the world there are two widely used diagnostic systems—*The International Classification of Diseases*, published by the World Health Organization, and *The Diagnostic and Statistical Manual*, published by the American Psychiatric Association. These are similar. The terms used in this book are common to both systems.

The continuum of care

Making the diagnosis is an early step in care. Most psychiatric disorders are chronic in nature and with the diagnosis, a lifetime of care begins. It is necessary to bring about remission, but comprehensive and integrated follow-up must also be arranged. It is often necessary to involve social workers and psychologists, the patient's relatives, the general practitioner and the community psychiatric nurse, in addition to the psychiatrist.

Introduction to psychiatric assessment

Introduction

A good diagnostic interview is the first step in good psychiatric care. It reveals the nature and extent of any mental disorder. As these findings are examined in the context of available therapeutic and social resources, the management plan is developed. (Interview findings may be supplemented by information from family, and special medical and psychological tests.)

The medical and psychiatric assessment processes are similar; both composed of two parts - history taking, and an examination. In history taking the clinician verbally explores the complaint and related matters; in the examination the clinician looks for other evidence of a disorder (in medicine this is called the physical examination, and in psychiatry it is called the mental state examination).

The physical examination begins with observation, and moves on to various other activities, depending on the system under consideration. Examples include setting the patients physical tasks (such as lifting an arm against resistance or discriminating between sharp and blunt stimuli) palpation and auscultation.

The mental state examination is mainly observation (visual, aural and olfactory). The patient may be set tasks to test abilities in abstract thinking, memory, concentration and theory of mind (the ability to be aware of the independent mental life of others). At times, it may be necessary to examine the tone of a limb to determine whether side-effects of medication are present, or to place a limb in a particular position to determine whether a particular mental disorder (catatonia) is present; but generally, the need for physical contact with the psychiatric patient during the mental state examination is rare.

It is important to remember, however, that psychiatric patients need a thorough medical assessment. Occasionally, patients present with psychiatric symptoms which are secondary to physical disorders, and require medical or surgical rather than psychiatric intervention (examples include thyroid disease, syphilis and human immunodeficiency virus infection, and space occupying lesion).

General approach to the patient

All patients have the right to respect and a duty of care (kindness, in pre-spin terminology). All psychiatric examinations and treatments should be conducted in privacy. Please, make sure the patient can understand what is being said - this means speaking clearly, and in the appropriate language. The clinician should introduce him/herself, so that the patient can identify the clinician by name. Patients should be addressed by name and they should be given ample opportunity to respond to questions put to them. During, or at the end of the interview, the patient should be given the opportunity to ask questions and the clinician should answer these as fully as possible.

It is important for the clinician to display respect and confidence. When the patient is receptive and insightful, things are relatively easy. When the patient is suspicious and hostile, however, things may be a little more difficult. It is important not to appear threatening to such a person. Thus, the eyes are downcast, the voice is lowered in volume and tone, the shoulders are relaxed rather than 'squared', in short, a somewhat submissive picture is projected. At the same time, there needs to be resolute confidence, as if to say, "This is important, I'm not here to hurt anyone, I'm determined to do my job".

It is not uncommon, when the author has interviewed a suspicious/hostile patient in the presence of students, for them to later comment that the patient "didn't make eye-contact". But, the patient could not have made eye-contact, even if inclined to do so, because the author was being submissive. While folk lore says that good eye-contact indicates trustworthiness, eye-contact is a central component of getting "in his face", and can be strongly challenging.

Questions may be classed as 'specific' or 'open ended'. Specific questions ask for specific information—the answer may be "yes" or "no" ("Are you married?") or some other fact ("How many children do you have?"). Open-ended questions, cannot be answered by one or a few facts, and generally require the collocutor to give an opinion ("What does being divorced mean to you?").

Both are needed in most conversations/interviews. They have different functions and present the collocutor with different tasks, and may trigger different emotional responses. A long list of specific questions may threaten individuals who fear persecution and interrogation, or irritate those who want to get on and talk about their distressing problem. Open ended questions are more likely to reveal disorder in the form and content of thought (but, unlikely to provide sufficient demographic information).

Interview skills (like all skills) are honed by practice. Students are encouraged to retrospectively analyze their own performance and the response of patients during clinician-patient interactions, as a means of learning to ask, at a particular moment, the right question in the right way.

A comprehensive psychiatric assessment depends on a large amount of facts and opinions. There is a large amount of questions to be asked and answered. But, there is no particular order in which these must be asked. Broadly speaking, clinicians begin interviews using one of two main approaches. Both have advantages and disadvantages and usually either can be used, but sometimes, one approach will suit a certain patient better than the other.

One approach (Approach 1) is similar to the standard medical approach, could be termed the 'standard approach'; some basic demographic information is gathered and quickly, the presenting complaint becomes the focus of attention.

The second approach (Approach 2) spends much more time on gathering demographic details and personal and family history before turning to the presenting complaint. The justification is that this leads to a fuller understanding of the personality of the patient, and that the presenting complaint will become clear as the life story of the individual is revealed. Further, it is natural that detailed questioning about earlier life events may frustrate patients who are keen/expecting to go straight to the presenting problem: clinicians interested in first understanding the personality of the patient are aware of such expectations and take notice of how any frustration is managed or expressed.

Specific and open ended questions are often interspersed. For example, should the answer to a specific question suggest there is further information which might be drawn out, a non-threatening open ended question may be useful:

Specific Question: "Do you feel guilty, at all?"

Answer: "Well.....a little."

Open Ended Question: "Can you please tell me about that?"

Asking for explanations is similar to asking open ended questions, and often gives good access to the patient's mental life. For example, the question, "Why did you come into hospital?" can be useful. The patient has often been brought in by relatives or the police and is not aware of his/her need for help. In such circumstances, the answer may be, "I don't know" or, "My family/the police misunderstood what I did/said".

In this situation the nuanced follow-up question, “Well, why do you think you were brought to hospital?”, or, “Well, why do you think they misunderstood?” may immediately tap into paranoid thinking and insightlessness.

Asking for explanations is recommended. It combats the frequent patient complaint that, the clinician “didn’t listen to me”. It is a good means of assessing form and content of thought, and insight.

Clinicians might avoid asking patients for explanations because when a patient explanation is provided, this is often followed by the sticky counter question, “You do believe me, don’t you?” The widely recommended (somewhat tricky) answer here is, “I believe you believe what you have just said”. By this point, deep down, most patients know that others do not “believe” their assessment of events. What they need/want to know is that they are safe and you can be trusted. An answer to the “You believe me, don’t you” question can be a pained expression and “I hear what you are saying, but I have to say, I’m not convinced”.

The Psychiatric History

As mentioned above, the order in which the details of the history are obtained is influenced by the mental state of the patient and the preference of the clinician.

Similarly, the order in which these details are arranged in the written record is a matter of clinician training and choice. For example, some choose to make a separate heading for 'Social Development' while others will place this information under the heading of 'Personal History' or 'Personality'; details of school life can be dealt with under a single heading, or placed under separate social, educational and personality headings.

Also, the arrangement of the components of the history may vary from one case to the next. All cases are not the same and some modification of the standard format (presented here) may better demonstrate the significant features of a particular case. For example, in general, more time, space and prominence will be given to childhood matters in the non-psychotic than in the psychotic disorders.

The following is a standard [modifiable] outline.

Demographic data

1. Name
2. Age
3. Religion
4. Race
5. Marital Status—single, married, divorced, widowed
6. Children—number, names, ages, live with or elsewhere
7. Education—elementary, secondary, trade, university
8. Employment Status—employed, unemployed, pensioner
9. Housing—flat, house, city, village, rural, renting, owner

The demographic details are important in a number of ways. They immediately suggest diagnostic possibilities and etiological factors. For example, a 19-year-old university student who has stopped attending classes and has been put out of his flat is more likely to be suffering schizophrenia than panic disorder; a 56-year-old factory owner who has not been to work for two weeks is more likely to be suffering depression than schizophrenia. Such diagnostic possibilities need to be substantiated, of course, but demographic details help reduce the search area.

The demographic details help us understand something of the background, aspirations and resources of the patient, the tasks faced, and the social supports which are likely to be available. Demographic information can help with treatment planning. For example, a 39-year-old married mother of four from a small village who attempts to hang herself, will probably require different services from a 17-year-old unemployed female resident of a large city who is experiencing relationship difficulties and attempts to hang herself.

The presenting complaint

In psychiatry, the term 'Presenting Complaint' is not always semantically correct. The patient may not present themselves, but be presented to the clinician by others, and may deny the existence of any complaint, in stead, asserting they "feel on top of the world". However, the term is used throughout medicine (including with unconscious patients who also neither present themselves nor offer a complaint) and the intended meaning is clear.

An account of the reasons for the presentation should (whenever possible) be obtained from: the patient; a relative or friend; and the referral source (this may be a doctor, or sometimes, the police).

It is acceptable to record the presenting complaint as a verbatim account - 'The patient said, "I heard all these murderers talking about how they are going to kill me with golden machetes"'. This form of recording gives the flavor of the presenting complaint, but it should not be used exclusively as the record becomes excessively long and complicated. Technical language summarizes information - thus, after exploring the above presenting complaint and clarifying the phenomena it may be possible to state: 'The patient presented complaining of auditory hallucinations. He heard three male voices plotting to kill him with golden machetes. He has the secondary delusion that his life is in danger'.

History of the presenting complaint

It may not be necessary to create a separate heading for this material, but details of how long the complaints have been present, any supposed triggering events and changes in the complaints/symptoms over time, should be elicited and recorded.

Psychiatric disorders often develop slowly and symptoms are often not recognized in the early stages - thus, questions such as the following might be asked:

- when did the patient last feel 'well' ("feel strong and rested, and 'positive'")

- when did the patient last function normally (“go about your daily life in your usual manner”)
- what was the first sign of change/symptom (“the very first thing you noticed”).

Similar, but subtly different questions may sometimes be helpful in clarifying symptoms of psychiatric disorder.

As well as exploring the temporal depth (how long symptoms have existed), it is necessary to explore the breadth of the history (the full cluster of ever present symptoms). This means asking about recent changes or symptoms which the patient may not automatically report. The presenting complaint will suggest some questions, for example, if the patient has attempted hanging and depressive disorder is suspected, in addition to mood, it is necessary to ask about changes in sleep, appetites and energy.

Some of the following questions should be asked of most (if not all) patients presenting for psychiatric assessment. It would not be appropriate to ask all of them of all patients.

- Changes in sleep - difficulty getting off to sleep (initial insomnia); waking in the middle of the night then getting back to sleep (middle insomnia); waking more than two hours earlier than usual and being unable to get back to sleep (early morning waking); disturbed sleep; waking unrefreshed; and excessive sleep.
- Changes in appetite (for food, sex, risk, drugs etc.) - any changes need to be quantified if possible – loss of appetite for food may be reflected weight loss or gain (how many kilos?), increase or decrease in alcohol intake (by how many standard drinks?), alteration in the frequency of sexual activity (what was the base and is the current frequency?).
- Changes in mood - depressed, sad, unhappy, fearful, worried, happy, elated, ‘tormented’ (by psychosis rather than mood disorder), heightened sense of spirituality (closer to God).
- Changes in energy - increased or decreased.
- Changes in interest in social contact - increased or decreased.
- Changes in thought content - new or unusual thoughts, new secrets which other people might not believe, suspicious behavior or persecution by others, repetitive thoughts which cannot be ignored (particularly clever thoughts which will solve problems or make a lot of money), repetitive “silly” thoughts that are your own, but you stop coming.
- Changes in the experience of thinking - sensation of thinking being more difficult, slower or mixed-up, sensation of thinking being faster, easier or more efficient.

- New perceptions.- hearing, seeing, touching, smelling that you haven't had before, or which other people might not be able to notice.
- New physical symptoms - pains, constipation, poor vision, fits, headache, muscular weakness, loss of consciousness.

Personal history

The personal history is an account of the events in the life of the patient to the present time. As mentioned, this material can be arranged according to choice. The following is one alternative.

Birth and early development

Events from the time before birth which may be relevant to the personal history can be placed here – for example, unwanted pregnancy, father absent at the time of birth, maternal starvation or accident during pregnancy.

Where mother is available or this information is otherwise retrievable, the following are recorded - the manner of birth (vaginal or caesarean); any complications or evidence of anoxia, the early development including age at which the patient first spoke and walked, comparisons with siblings and any evidence of delays or precocity.

Family history

The family history gives an account of the relationships the patient experienced during development, and in the case of some patients, is currently experiencing.

1. Who raised the patient?
2. Was there an adult of both sexes in the home?
3. Were either of the parents away from the home for long periods?
4. Were either, neither or both parents emotionally close to the patient?
5. How many children were there in the family and what were their names?
6. Where did the patient come in the sib-ship and what were the age differences?
7. With which siblings did the patient have the closest emotional relationship?
8. How would the patient describe each parent figure?
9. How would the patient describe the family life of his or her early years - warm, frightening, etc.
10. Were any other significant adults present during development?

School history

The school history offers very valuable information. During the school years, students must function in different roles (studies and sports participant, subject to

rules and authority, friend and helper) in standard settings, over an extended period of time. Thus, much objective data is available and performance/behavioral patterns/responses can be evaluated.

Patients can be asked the following questions, first in relation to primary school life, and then in relation to secondary school life.

1. How did you perform scholastically (“in lessons and tests”)?

(Most primary school lessons and tests are within the ability of most students. A history of having found these difficult may suggest intellectual disability, or a severely disorganized home life.

Good scholastic performance in primary school followed by poor scholastic performance in secondary school suggests an inability to comply and delay gratification (home-work) which may indicate an emerging personality disorder; alternatively, and less commonly, an prodromal psychosis.)

2. How did you get along with the other students?

(Most primary school students have at least some friends. A history of few friends or being very socially isolated suggests avoidant or schizoid traits or prodromal psychosis. A history of being ‘popular’ and frequent falling out (“fights”) suggests emerging Cluster B personality disorder. A history of few friends but above average school performance suggests obsessional traits.)

3. How did you get along with the teachers?

(Most primary school students have a satisfactory relationship with teachers. Shyness of primary school teachers may predict an anxiety disorder or Cluster C (anxious/fearful) personality traits.

Teachers symbolize authority. Conflict with teachers often emerges in secondary school (although in pronounced cases it may be present in primary school) suggest the individual may not comply with the rules of society, in adult years).

4. Was the individual involved in other school activities?

(Some young people have as little to do with school as possible. Others engage in choirs, sporting and similar activities both in and outside school hours. Such engagement suggests ability to delay gratification and derive pleasure from social interaction; and in the case of sport, some confidence in physical ability.)

Sometimes, something can be learnt by asking about the attitudes and behavior of friends. Talking about their friends allows individuals to talk about themselves, “at arms length”. Occasionally, individuals take pleasure in reporting the antisocial

behavior of their friends. It can be that what is said is less informative than how it is said.

Employment history

Higher education can be considered separately, or as the early part of employment history (as is apprenticeship).

The employment history gives a valuable, sequential account of the ability of the individual to perform a demanding adult function. It is useful to obtain account, as complete as possible, of:

- the type of work pursued;
- the dates of employment (starting and leaving); and
- the name of each employer.

It is also useful to know the reason for leaving each employer, and whether there was difficulty in finding the next position. The dates of employment give the length of any periods of unemployment. If the patient claims an extensive work history, it would be expected that a list of names of employers could be given. Inability to provide details with a relative ease suggests cognitive difficulties, secretiveness (perhaps paranoid or deceptive in origin), or that employment was only fleeting.

Sexual, reproductive and cohabitation history

These are separate subjects, but may be grouped together to reduce the number of separate headings.

The **sexual history** includes the answers to the following questions (among others).

1. What was the attitude of the parents to sexual intimacy?
2. Did the patient ever see the parents naked?
3. How did the patient learn about sexual intimacy?
4. When was the menarche?
5. When did the patient first masturbate?
6. When and with whom was the first sexual encounter?
7. Has there been incest, rape or domestic violence?
8. Has there been homosexual contact?
9. What is the current sexual orientation?

10. How satisfactory is the patient's sex life? (includes frequency of activity)

Caution - sexual matters are among the most sensitive personal issues. The clinician needs to exercise judgment. The facts of the sexual history may be interwoven with embarrassment, shame, fear, disgust, and other powerful emotions. In cases where the sexual history is probably of less relevance, such as with an acutely psychotic middle-aged patient with a long history of psychosis, it is acceptable to truncate the sexual history, at least during an acute exacerbation. In the case of individuals for whom the sexual history is of probable importance, such as a patient presenting with impotence, it may be advisable to proceed slowly and allow the patient-clinician relationship to strengthen before obtaining all necessary details.

The **reproductive history** includes the answers to the following questions (among others).

1. Has the patient reproduced?
2. If no to 1, have there been attempts and are there regrets?
3. If no to 1, have there been termination/s of pregnancy?
4. If yes to 1, dates and details of births?
5. If yes to 1, what relationship does the patient now have with the offspring?
6. In the case of women who have reproduced, was there evidence of post partum mental disorder?
7. Is the patient using contraception?
8. Does the patient wish to reproduce in the future?

Caution - reproductive history is another potentially sensitive area, especially where there has been illegitimate pregnancy of which other family members are unaware, still-birth or infertility due to earlier sexually transmitted disease. The clinician should exercise judgment.

The **cohabitation history** is an account of the periods (names and dates, preferably) during which the patient lived in a permanent or semi-permanent sexual relationship with another (of either sex). The events at the end of the relationships and the length of time between relationships are important.

Past medical and psychiatric history

Record serious medical illness/injury which may have impaired the individual's development, either by reducing opportunities, for example, as in the case of severe asthma, or by directly affecting brain function as may occur in head injury.

Record, in detail, any past psychiatric treatment.

Family medical or psychiatric history

First ask about any known family medical or psychiatric disorders. Then enquire specifically about the past and present medical and psychiatric health of grandparents, parents, uncles, aunts and cousins. It is common for an individual to deny/be unaware of family pathology, which becomes highly probable if individual family members are briefly discussed.

Ask whether any relatives spent time in a psychiatric hospital.

Ask about suicide, alcohol abuse and convictions (evidence suggest, in some cases, these may be variants of mood disorder).

Personality

In the psychiatric setting, the personality of the individual is of profound importance. But, what *is* 'personality'? In one dictionary of psychology, a learned scholar wrote (Reber, 1985) "a term so resistant to definition and so broad in usage that no coherent simple statement about it can be made". And, when a psychological test of personality is conducted, the result comes back as a set of numbers indicating how the individual scores on a number of scales such as "impulsivity", "optimism" and "agreeableness", which are of limited usefulness in the diagnostic and prognostication purposes.

The most clinically useful definition/description states that personality is those features of the individual which determine his/her unique adjustment to the environment (human and non-human; Cloninger et al, 1993). This apparently simple observation is deeply wise. It is consistent with the observation that past behavior predicts future behavior. It has face validity, we know which of our friends to invite to certain functions, because we know them (their personalities) we can predict their responses (who would 'fit in' and who would not)

Thus, we are all have ‘a personality’, and we are all different. Margaret Mead (1901-1978), influential anthropologist and feminist, made the statement (which has been lampooned but remains an axiom): “Always remember that you are unique. Just like everyone else.”

We need to remain alert to the fact that people can have very different personalities, and be completely healthy and functional. (Figure 1)

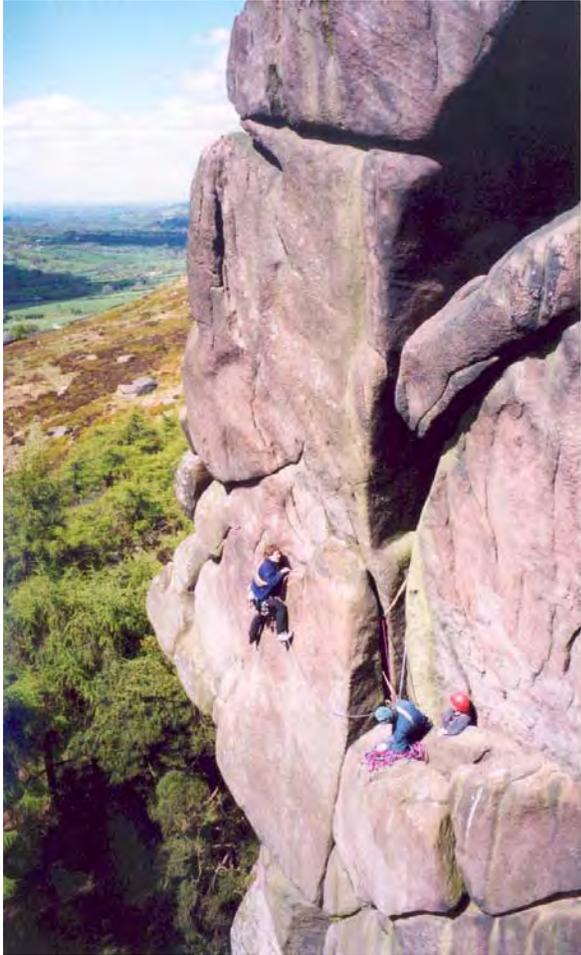


Figure 1. Three people rock climbing. This image almost makes the author nauseous, but these people are doing this for ‘fun’. The author finds it hard not to use words like “crazy” and “madness”, but that would be wrong. These people are in peak physical shape, they have trained (delayed gratification) for many years and are engaged, as a team, in recreation. This shows how different of similar backgrounds can be, without invoking the concept of mental disorder. (Climber on "Valkyrie" at The Roaches in Staffordshire, United Kingdom; Source, English Wikipedia; Date, 9 August 2004; Author, [Gdr](#); Permission, GFDL)

Because personality is reflected in responses, we can economically learn about the personality of the individual by examining his/her behavior during periods of change and challenge.

Because personality is reflected in responses we learn much 1) from the personal history, and 2) when we observe the patient's responses to the interviewer and the psychiatric interview situation. Thus, personality assessment is unique, as it stands astride, with one foot in the psychiatric history and the other in the mental state examination. But, there are, of course, other legs, including the individual's own opinion and the opinion of others about what the individual is "like". See below.

As stated above, personality is profoundly important. Personality assessment sometimes leads directly to a diagnosis (of personality disorder), but always lead to a better understanding of individual's response portfolio, and his/her responses will greatly influence the outcomes of any and all medical or psychiatric disorders.

In addition, of course, certain personality features (obsessionality, shyness, irritability, alexithymia) may influence our ability to obtain a "good" history.

Traits, features and predispositions

Personality is has been described as the characteristic responses made by the individual to changes and challenges. Another aspect of personality study is the more fine-grained examination of personality traits, features and predispositions, which underpin and shape responses.

Traits, features and predispositions deserving consideration include the following:

1. Predominant attitudes toward him/herself, other people, material objects and institutions;
2. Ability/attitude to planning for the future;
3. Ability/attitude to sustained effort;
4. Ability/attitude to tolerating frustration;
5. Ability to trust others and sustain relationships;
6. Coping style – methodical, forceful, measured, dependent, manipulative (Figure, 2);
7. Capacity for emotional warmth;
8. Psychological mindedness (the ability to understand events from the psychological perspective)/theory of mind;
9. Superego development (internalized values or conscience);
10. Alexithymia. This term (from Geek) is translated as "without words for emotions" (Sifneos, 1996). It is a personality trait in which the individual has

difficulty identifying his/her emotions and finding the words to describe them to others. Afflicted individuals also tend to lack a fantasy life, respond to all situations in a cognitive manner, and to lack the ability to experience pleasure (anhedonia). Alexithymia is common in some physical disorders such as hypertension and irritable bowel syndrome, roughly expressed, the theory arises that stress impacts on the body because it cannot be dealt with by mental processes. It is also common in a range of psychiatric disorders including substance abuse and some personality disorders. Alexithymia creates interpersonal problems, when these, or other problems arise, some alexithymic individuals get some relief from self cutting (as a stress release mechanism).

While theory of mind is the ability to understand the emotional state of others, alexithymia is concerned with the individual's own emotional life. It comes as no surprise that 85% of people with autism spectrum disorders also have alexithymia (Hill et al, 2004). This "overlap" needs to be explored.

Various tests of alexithymia have been developed (Vorst & Bermond, 2001). These are not used at the diagnostic interview, but may have a place later care. In the clinical setting, make an effort to (at least) discover the ability of the patient to recognize and describe their emotions and experience pleasure.



Figure 2. This ceramic model headstone was crafted by a middle-aged man with a histrionic personality disorder. He was admitted to a psychiatric hospital following a failed relationship, with what would now be diagnosed as an adjustment disorder with depressed mood. This was in the time when such places had occupational therapy departments, and the pressure to discharge patients was not as has become.

Ten days after admission this patient went to the occupational therapy department and completed the first step of construction - a wet clay model of a headstone

bearing the letters RIP, his own initials and a date about two weeks in the future. There was concern among staff regarding possible suicide, but as this was considered to be attention seeking behavior, the model was not discussed with him. He was, however, unobtrusively watched more closely. Subsequently, the patient dried the model in the kiln and finally, glazed and fired it. He never mentioned his model, but displayed it prominently at every step of construction. His condition improved, the headstone date passed and he was discharged. He left the model unclaimed in the occupational therapy department and it was thrown out a year later. The patient was alive three decades later. The important features were the dramatic and attention-seeking behavior associated with making this model, and the superficiality suggested by it remaining unclaimed.

The Psychobiological Model of Personality (Cloninger et al, 1993) deserves mention. It may have a significant effect on psychiatric thinking. In this theory, personality is divided into temperament and character. Temperament refers to the automatic responses of the individual to emotional stimuli, and has four dimensions: harm avoidance, novelty seeking, reward dependence and persistence. Character refers to voluntary goals and values, which are based on concepts of self, other people and other, and has three dimensions: self-directedness, cooperativeness and self-transcendence.

In personality disorder the individual fails to take responsibility for his/her actions and is often in conflict with others. In the Psychobiological Model of Personality, personality disorder exists where there is a deficit in character (particularly where there is low self-directedness and cooperativeness). Features of temperament do not determine the presence or absence of personality disorder, but if personality disorder is present, temperament will influence the type/manifestation.

For example, consider high levels of novelty seeking - where there is healthy character development, high novelty seeking may lead to a quiet life in research, while where there is low self-directedness and cooperativeness, high novelty seeking may lead to irresponsible, even criminal, behavior.

The Temperament and Character Inventory (Cloninger et al, 1993) quantifies these 7 factors (self determination, cooperativeness, harm avoidance, novelty seeking, reward dependence, and persistence).

The Five-Factor Model of personality (McRae & John, 1992) is widely accepted, and focuses on five dimensions: openness, conscientiousness, extraversion,

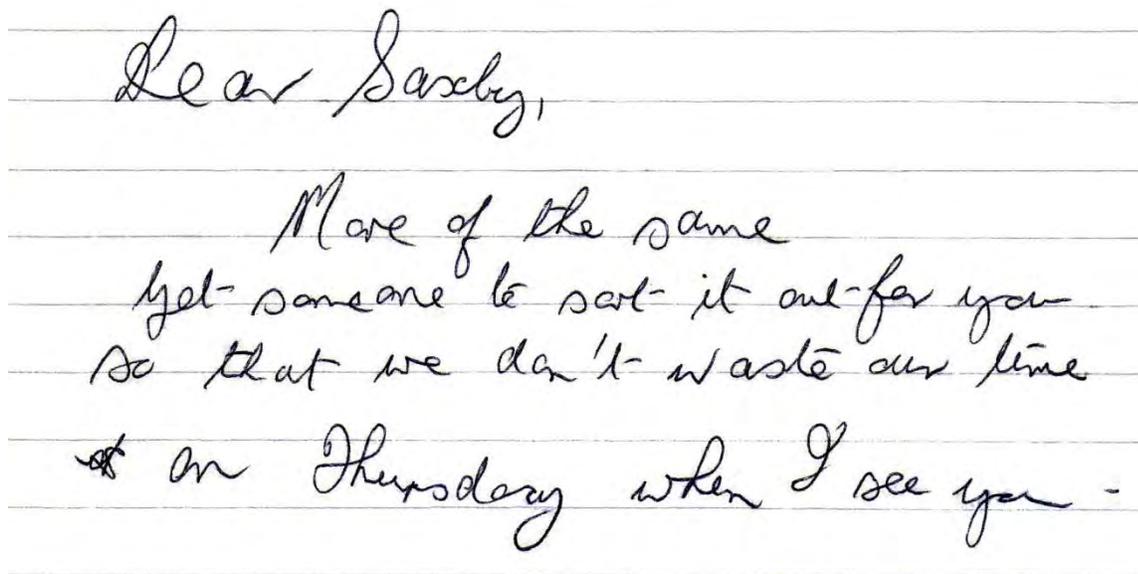
agreeableness, and neuroticism (tendency to pessimism), collected by the acronym OCEAN.

Personality inventories and tests such as the TCI and FFM are not used in the diagnostic interview setting. But, the associated factors and dimensions may be helpful as we attempt to conceptualize the personality of particular individuals.

Trait and state

A trait is an enduring characteristic of a person which helps to explain regularities in behavior. Personality can be understood as a constellation of traits. A state is the set of conditions which exist at a particular time. While in political terminology, a state is considered to be relatively enduring, in psychiatry the term indicates a set of conditions which have not always existed and may change (such as an acute psychosis).

In the psychiatric interview, trait and state features need to be distinguished from each other. For example, major depressive disorder may feature isolativeness and reduced conversation, which needs to be distinguished from Cluster C personality disorder; mania often features grandiosity, which needs to be distinguished from Cluster B personality disorder (Figure 3).



Dear Saxeby,
More of the same
get someone to sort it out for you
so that we don't waste our time
on Thursday when I see you -

Figure 3. This cover note was written by an ordinarily sedate, elderly woman who suffered mania. During acute episodes she would write prolifically and send or bring her doctor rambling letters of up to twenty pages. The above note was

attached to one such letter. Disinhibition was demonstrated in her uncharacteristic use of her doctor's Christian name - a departure from their usual arrangement. There was also grandiosity in her words, 'Get someone to sort it out for you so that we don't waste our time...' This is a state feature and not the entitlement observed in narcissistic personality disorder.

Sources of information

There are four main sources of information regarding personality.

1. Personal history - The personal history has been described. It is an unambiguous account, over decades, of the patient's responses. The school history gives information of responses to scholastic interpersonal and sporting challenges in the important years from childhood to late adolescents. The work and sexual/cohabitation/reproductive histories give accounts of the individual's response in important areas of life (Sigmund Freud (1856-1939) claimed, "Love and work are the cornerstones of our humanness" and also, "Love and work...work and love, that's all there is".)

2. Patient's opinion - The patient's opinion of his/her own personality is valuable. It may reflect the opinion of others, in which case there would appear to be a degree of self-awareness; it may conflict with the opinion of others, in which case we need to understand the basis of the divergence.

The patient may be asked to:

- give an account of his or her own personality ("How would you describe yourself, what are you like? I mean, are you better with your hands or your brains?" After some discussion, perhaps, "What would you say are your strengths, and if you have any weaknesses, what would you say they are?")
- predict what others would say of him/her if they were asked the same question. This may reveal paranoid, hostile/aggressive or insecure characteristics. ("If I asked other people, like your family or the people where you work, what you're like, and what were your strengths and weaknesses, what would they say?")

3. Friends'/relatives' opinions - A friend or relative will be able to give an account based on years of real life experience. The clinician will need to exercise some judgment, as the observations of family and friends may not be totally objective. However, they often have useful information. (Figure 4.)

“Dear Sir,

I have addressed this letter to you – PERSONALLY - because I am sure that a lot of letters do not ever make it past the Secretary’s desk. I cannot even be sure that this will - but that some ‘industrious’ assistant will open this and not even let you see it. Well, I shall risk that - since I really do not have any choice - do I? This may eventually end up in the garbage (where probably plenty of correspondence, which takes hours - and time and money for the person concerned). This is even more regrettable - when one cannot afford to be writing in the first place (and is a Pensioner like myself - but not an aged one, so I’m not some ‘little old lady’ who neither knows what she is talking about - nor can make up her own mind and is incapable of making a decision, without blindly being dragged into accepting things). On the contrary - God gave me a mind, and a choice - in that I have a will. I will therefore exercise that will - and not be ‘forced’ to accept your blusterings, and of other people in this Government. So before, you put this in the garbage (if that is what you intend to do - and I am NOT being unkind in saying that - I actually heard a politician on Television - some years ago say that some (probably a lot) of the mail she got - she put straight down her toilet. PLEASE READ IT. Now I know that there may be some weird letters written in this world - but this really is a demonstrably disgusting and implicating statement - to make on national television - for all and sundry to hear. It most definitely makes people wonder if their mail really is given any priority or consideration. I have had a whole lot through my life impressed upon me, to confirm me in the opinion, that in some cases - it is not...”

Figure 4. This is a facsimile of half of the first paragraph of a four-page letter sent to a politician. It was provided to medical staff by the relatives of a patient to assist in the diagnostic process. In the original letter there was very little space at the top and bottom of the pages, a 5mm margin on the left and a 1 mm margin on the right of the page, and only two paragraphs per page (both unusually large, of course). It was single spaced and the type was small. Thus, the pages are densely covered with print. Emphasis was achieved by underlining certain words and placing others in capitals. The correspondent opens with concern that the letter may not receive due consideration from the recipient. Only one other matter is raised and this is what the correspondent describes as “misplaced encouragement afforded” to two minority groups.

There is no disorder in the form or content of thought (described later). There is a repetitious, ponderous style with no warmth. While no paranoid delusions are

present, there is intolerance and anger. The question of morality is raised and a dictionary definition given. This letter is of the kind written by individuals with obsessive-compulsive personality disorder.

4. The interview situation - The above personality information is based on historical reports by the patient and others, all or whom are probably untrained. The interview situation, however, gives the opportunity for first hand observation of the patient's interpersonal behavior. In this regard the assessment of personality is similar to the mental state examination.

Does the patient respond in the interview situation with appropriate decorum, does he/she display undue informality, irritability or seductiveness? Does the patient attempt to make the clinician or others responsible for his/her situation. Is the patient able to use humor and other healthy coping skills, or is there excessive use of obsessional detail (Figure 4) 'rationalization' (in psychoanalytic theory, the use of 'rational/good' reasons in place of the 'real' reasons; in everyday use, the making of excuses) and denial (in psychoanalytic theory, a defense mechanism which simply denies thoughts, feelings or wishes).

Motivation, apathy and will

Inclusion of this section in the assessment of the psychiatric patient is controversial. It is a difficult area, incorporating philosophy and the history of ideas, and a detailed discussion is beyond the scope of this book (not to mention the grasp of the author). In ancient Greece the psyche was conceptualized as composed of three parts: affect (feeling), cognition (knowing) and conation (that aspect of the mental processes having to do with volition, striving and willing). The close integration of the components of the psyche makes their separation difficult and Kaplan and Saddock (1998) places conation under the heading of motor behavior.

Berrios (1996) finds value in the concept of the will. He notes that toward the end of the nineteenth century it became 'a casualty of fashion' and fell from use, a fall hastened by the rise of psychoanalysis and behaviorism. Berrios and Gili (1995) believe that the will was an important descriptive and explanatory concept and that removal led to a conceptual vacuum in the domain of volition, which has been unsatisfactorily filled by notions of instinct, drive, motivation, etc. They contend

that will remains ‘central to psychiatry’ and that it is relevant to personality disorder, chronic fatigue syndrome and forensic psychiatry.

Silva and Martin (1999) made a useful contribution. They described apathy as the diminution in motivation (observable goal-directed behavior) relative to a person’s age and culture, claiming it becomes clinically significant when severe enough to interfere with psychosocial functioning. They report that apathy occurs in a range of neuropsychiatric and medical conditions including dementia, frontal lobe syndrome, basal ganglia disease, stroke, depression and psychotic disorders. To this list could be reasonably added, personality disorder.

Observers usually agree that individuals differ in their motivation (goal-directed behavior) and that while one individual may be highly motivated in a many aspects of life, another may be highly motivated in only one (a hobby, perhaps, collecting stamps). But if the topic is approached from another direction, questions may be raised about what is energizing or directing the motivation and perhaps that is the Holy Grail we should be pursuing.

The question of ‘will’ also appears to be multilayered. First, there is the aspect of energy (Plato used the term ‘bouelsis’ in the discussion of will, a word which is related to boiling and exuberant) and second, there is the choice regarding how to direct that energy. Kant (1909) stated that the will ‘is conceived as a faculty of determining oneself to action...’ - the word ‘determining’ conveying a measure of choice or deciding on direction. For present purposes, consideration is given only of the evidence of motivation and not to the associated issues of choice.

It is believed possible to make a statement about the amount of motivation demonstrated by a patient. There is need for caution as there is a danger that the clinician may appear to be making a moral judgment. Using the term ‘will’, for example, leads to classifications of ‘strong willed’ and ‘weak willed’ – while technically defensible, such classifications could expose the clinician to criticism.

The term ‘motivation’ is a possible substitute - the patient can be placed on a continuum from ‘highly motivated’ to ‘lacking motivation’, the latter term being more socially acceptable than ‘weak willed’. As an Apathy Evaluation Scale (Martin *et al.*, 1991) has been created and validated, ‘apathy’ is also a suitable choice. Patients can be rated from ‘highly motivated’ to ‘no evidence of apathy’ and on to ‘severely apathetic’.

Where comment on motivation, apathy and should appear in the written assessment is flexible. These elements are closely related to motor behavior, however, they are also touched on in personal history, and parts are included under personality. Like personality, they sit astride the history-examination border. Therefore, it is recommended that motivation, apathy and will follow the entry on personality.

Diagnostic considerations related to motivation

Many mental disorders manifest symptoms of motivation/will/apathy type.

Depression

Particularly in major depressive episodes, the depressed patient may complain of loss of motivation and disabling fatigue. This may be associated with slowed movement and thinking (psychomotor retardation). These are biological or vegetative features of this biological/psychiatric disorder, but the patient may interpret them as moral or character flaws. Such a view may accentuate self-loathing and delusions of guilt. All of these symptoms, including the loss of motivation and disabling fatigue, are reduced by effective treatment.

Schizophrenia

Patients with schizophrenia sometimes complain of a loss of motivation. More often, it is family, friends or health professionals who make this observation. It is one of the “negative symptoms” of schizophrenia, the others being loss of affect and poverty of thought. Some combination of these may lead to the often observed self-neglect of schizophrenia, but an understanding of self-neglect in this disorder is yet to be apprehended. These negative symptoms are notoriously unresponsive to treatment.

Neurasthenia and fatigue syndromes

Neurasthenia is a diagnostic category which has been rejected by some authorities. It appears in ICD-10, and there are two main types. In one, after mental effort, there is mental fatigue which “is typically described as an unpleasant intrusion of distracting associations or recollections, difficulty in concentrating, and generally inefficient thinking”. In the other, after minimal physical effort there are feelings of physical weakness, muscular aches and an inability to relax. There are other symptoms, but the hallmark is fatigability and weakness. To make this diagnosis, one must first exclude physical or other psychiatric causes.

Personality disorder

In early diagnostic classifications there was an “inadequate” personality

category. Such individuals were believed to lack motivation. No such category is now recognized.