Synopsis
Of
Clinical Psychiatric Assessment

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Preface

Along the past century, a lot of successively changing views had governed the field of psychiatry, with psychoanalytic theories dominating at one time, and behavioral, cognitive, biological theories dominating at other times. These changes have a great effect on the aim and the techniques of evaluation of psychiatric patients, where it takes the form of either intensive study of the patient's life and his surrounding environment or the form of brief evaluation the did not consider the complexity of human behavior.

Though overlap and controversy of the terms used to discuss psychiatric symptoms, this book tried to include a scheme of all possible symptoms that could bring the patient to psychiatric attention, in a simple language that avoid ambiguous descriptions and that tried to discuss vague ones. So, I hope that this manual be useful for medical students and residents working in the field of mental health in their early career.

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Notice: this work is intended to help medical students and residents of Neuropsychiatry in their early career. Anyone can make a copy for personal use or none commercial use.

Introduction

At the beginning of work with psychiatric patients, students and residents have already learned much about the process of medical evaluation. They know how to detect signs and symptoms of illness by taking history and performing a physical examination. They have also learned how to use a guide to laboratory testing and to appreciate the relevance of these findings to diagnosis and treatment. These skills are all necessary, though insufficient, in evaluating psychiatric patients.

Many of the difficulties of learning to be psychiatrist are determined by the differences between mental and physical illnesses. The traditional educational approach in psychiatry is to encourage students to ignore or minimize these differences and to emphasize similarities between all illnesses. Though that approach is assuring to students, it can retard or inhibit their capacity to grasp issues that are critical for psychiatric evaluation and management.

Psychiatric disorders are defined and classified primarily on the basis of observations of the patient's behavior and experience. This requires the psychiatrist both to become more thorough and skillful in using traditional medical methods of evaluation and to develop new skills that are unlikely to be learned in the process of traditional medical evaluation. **The psychiatrist must be skilled in:**

1) How to obtain accurate descriptions of abnormal behavior from the patient and other observers.
2) How to make direct observations of the patient current behavior. Skills in detecting current behavioral aberrations are essentials, in particular, patterns that appear during the process of evaluation.
3) Taking an extensive history that focuses on past behavior and experience.
4) Helping patient to communicate inner experience. Thoughts, feelings, and perceptions are private phenomena, and many patients are unwilling or unable to discuss them with the physician. One of the first skills that psychiatrists must master is how to ask questions about inner experiences that the patients can understand and answer.
5) Testing for disorders of perception, thought, and feelings.
6) Determining how behavioral and experiential difficulties may be related. Sometimes inner experience can be inferred by observing deviant patterns of behavior; e.g., patients who are withdrawn and tearful are likely to feel sad. The reverse is true; behavior may be predicted by learning about inner experiences, e.g., patients with uncontrollable feelings of anger are at greater risk of behaving violently than those who does not.
7) Detecting inaccurate history: the accuracy with which patient reports or reveal experience. It is usually difficult to understand why some patients would voluntarily or involuntarily seek to create or exaggerate symptoms. There are many reasons for psychiatric patients to withhold, to minimize or exaggerate or even fabricate information:
   - The patient lacks the cognitive or expressive capacities to communicate essential data to the evaluator.
   - Some patients with dissociative disorder experience difficulty in recalling important personal events.

- Some patients perceive the interview as stressful situation. The stress of the interview diminishes the capacity of some patients to think and communicate clearly.
- Some patients intentionally withhold information to avoid humiliation; due to fear of mental illness and concern about stigmatization, either by the therapist or others.
- Memory loss may be accompanied by a trial from the patient to hide this deficit.
- Wishes for more attention.
- Seek for some form of excuse from responsibility, often lead to inaccurate reporting.

The psychiatrist must, therefore, develop skills and competence to determine when patients are presenting misleading information.

How to detect that the patient is withholding or provide inaccurate information: ***there are certain cues that alert the clinician about the sufficiency or accuracy of communication:***

1. The patient answers questions briefly even when asked to expand on these answers.
2. Giving statements of ignorance or amnesia when asked about certain topic, e.g., I do not know, I do not remember; changing the subject; or shows changes in the attitudes toward the interviewer.
3. Giving contradictory information.
4. The patient may try to take control of the interview by insisting on limiting disclosures only to subjects that he or she chooses.
5. The patient may be obviously exaggerating, e.g., when I had this headache I go blind for hours at a time.
6. Patients may deny the existence of experiences or events that would be easily inferred from their behavior, e.g., patients who break into tearing while insisting he is feeling fine.
7. The patients change his or her information in response to suggestions by the clinician.
8. The patient may simply state that there is something that he or she is unwilling or unable to discuss.

Information necessary to be obtained for clinical evaluation:

The parameters of the degree of voluntariness, the site of evaluation (in- or outpatient), and the degree of urgency all have some influence on the manner in which the physician goes about collecting information about.

A- When time is available

1) Why the patient has requested or has been sent for evaluation at this particular time. Patients may seek treatment as outpatients or as inpatients. Some outpatients are in urgent need for care and may come or are involuntarily brought to emergency rooms; others come to regular clinics, either voluntarily or involuntarily. Inpatients may be admitted voluntarily or involuntarily, or seen in medical or surgical wards. Patients may also be brought for forensic evaluation.
2) The events that precede and that may determine why the patient is seeking or has been sent for help. This information is referred to as history of the present illness. It is essentially a chronology of what has happened (or more precisely, how the

patient has interacted with the environment, usually in a maladaptive manner), from the time just preceding the symptoms until present.

3) The patient's current and past medical history, including all psychiatric symptoms and previous psychiatric treatment. It is convenient to consider the family health history (i.e., mental and physical health of the extended family) under this heading.
4) The patient's personal history including childhood development, educational experiences, work and military experiences, and patterns of relating to others. The family relationship history may be included here.
5) The patient's current life situation. Here, two factors are evaluated:
   - The patient's current environment, with an emphasis on how it contributes to the patient's symptomatology.
   - The predominant personality traits. This information help clarify how the patient's difficulties had developed, And how the patient is with them.

B- When time is limited: in emergency room the evaluation should focus on:

1) Assessment of vital signs.
2) The reasons for the patient's seeking or being sent or evaluation now.
3) History of current and past medical problems.
4) The severity of symptoms and current level of functioning.
5) Suicidal or homicidal ideation.
6) Other aspects of mental state examination.

Though it is important to develop the skill of brief evaluation, it is to be stressed that there a risk to be inaccurate and the importance of later comprehensive evaluation.

How should the interview be initiated?

There is no uniform approach to begin a psychiatric interview. The only role of thumb is that physicians should begin by introducing themselves and saying something about their status. This if followed by greeting companions if the patient is accompanied and explaining how long they may have to wait and whether they will be interviewed. It is usual to interview the patient alone first and other informants afterwards, with the patient's consent. Let the patient know from the outset how long the interview is likely to take and that you will be taking notes at some stage (which are confidential). There are three opening maneuvers.

1) Ascertaining the patient's chief complaints by asking questions such as " what brings you here?" "How can I help you?" or "what is the main thing bothering you?"
2) Inquiring about the demographic data such as the patient's age, occupation, marital state, and residence.
3) The physician tell the patient a little bit more about himself by elaborating on his or her level of responsibility for the patient care, the kind of work he or she usually does, and how long he or she has been doing it.

Perhaps the majority of patients respond best to straightforward inquiry about what is troubling them. This is especially true of voluntary patients who may be eager to seek help and want to get right to the business of telling their story. In the case on involuntarily hospitalized patients, a straightforward inquiry may elicit annoyed or defensive responses in the patient. The patient usually best responds to questions like; "what brought you here" or "why are you here and how can I help you?".

Psychiatric Assessment

Psychiatric interview is main tool in evaluating patients who complain of symptoms which were assumed to be due to represent mental disorder. It includes assessment of the patient's history and mental state examination. Complete physical examination is essential in some cases, to ascertain or exclude the presence of physical disease.

I- History taking

Personal Data

Name: it is of value in

1. Identification of the patient: this facilitates communications and gives a sense of familiarity.
2. Registration: this helps in the follow up of the patient and in future researches.
3. Giving the name may reflect suspiciousness of the patient, e.g., a patient may hide his or her name.
4. Some patient may be traumatized by their names.
5. The name may reflect the patient's culture (certain names are common in certain cultures, also, certain names are used to prevent death of children "prevent the eye").

Age:

- Certain diseases are most common at certain ages, e.g., schizophrenia is more common in young patients. Dementia is common in the elderly.
- Prognosis differs according to age, e.g., prognosis of schizophrenia is better in cases with onset after puberty.
- Knowing age is important in adjusting doses of drugs.

Gender:

A) Incidence of different disorders may differ in both males and females, e.g., in males; antisocial personality and alcohol and drug abuse are more common. In females anorexia and bulimia nervosa, and depression are more common

B) Age of Onset, course, and prognosis of different disorders may differ in both males and females, e.g., in schizophrenia males have earlier onset and poorer prognosis.

Address: it is of value in

- Registration: this important in the follow up and retrospective studies.
- It may give knowledge about the patient's culture and socioeconomic state.

Culture and socioeconomic state may:

1. Shape the patient's symptoms e.g. a depressed patient may not mention that he is depressed as he thinks that this is an objection to the will of God.
2. Reflect awareness and knowledge about psychiatric illness (some

cultures do not consider psychiatric illnesses).

3. Reflect degree of support system and expected compliance (rural areas are characterized by marked family and social support).
4. Affect the prognosis of the illness e.g. in schizophrenia, deterioration of social roles become marked in urban than in rural areas because of multiple responsibilities and duties of persons living in urban areas.

Occupation

The current employment state, e.g., unemployed; on bench; homemaker; student; skilled or unskilled manual worker, clerical, sales, technician, or farmer; owner small business, minor professional, or administrative personnel; major professional and high executive. Detailed occupational history is taken later on.

Marital state (Civil Status):

Includes; identifying the patient as Married, separated, divorced, widow, or single, and the number of living children (if present).

Religion: Being Muslim, Christian, Jewish or others.

Religious beliefs add meaning to life and enable patients to deal with daily stress, tragedy, and the existential issue of death. They also play an important role in the development of one's conscience and value system.

The involvement in certain religious group may provide nurturance or conversely may be a source of new stress. So, it is useful to inquire about the effect of religion on the patient's upbringing and about the kinds of religious beliefs and experiences which the patients had throughout their lives.

Knowledge of the patient's religious belief may also influence treatment planning. Patients who have strong fundamentalist beliefs may not respond well to psychotherapies that emphasize expression of feelings, particularly anger, or that encourage confrontation.

The key issue in taking a religious history is the physician's capacity to show respect for the patient's belief system. All patients should be asked about the nature and depth of their religious beliefs. The patients who deny religious beliefs can be asked, "are there other beliefs that provide meaning for you or help you cope with stress such as tragedy or death?". Most people have thoughts about these issues and are willing to discuss them.

Source of referral:

The patient may come to psychiatric clinic by his well or referred from other authority for assessment. Those may be

a. A member of the family.

b. A work authority.

c. Legal (or police) authorities.

d. Other medical specialties.

Cause of referral: the patient may be referred for a variety of causes

1) Personal suffering, e.g., depressed mood, obsession, compulsion, insomnia, sexual dysfunction.
2) Threats of dangerousness: the patient may be suicidal or homicidal.
3) Relief of the family; due to difficulties of dealing with the patient because of his illness.
4) Assessment of legal responsibility; when referred from court.
5) Marital or premarital counseling.

Type of admission:

In cases of inpatients; the patient may be admitted to the hospital voluntarily or compulsory admission. This may denote the degree of patient's insight. Both types of admission are different from the administrative point of view.

Other sources of Information;

Sometimes, other sources of information are essential to reach or ascertain a diagnosis and assess its impact on the patient in different situations (academic, family, social or work). These include relatives, friends, and school or work reports.

Details about certain informants include name, age, sex, occupation, relation to the patient, intimacy, length of acquaintance and previous hospital records if available and lastly, the interviewer's impression of informant's reliability and their level of cooperation.

Chief Complaint

Chief complaint should always be stated in the patient's own words. Although the patient's family may describe the problem quite differently, the manner in which the patient perceives events is of great importance to the psychiatrist. Precise recording of the chief complaint permits the psychiatrist to review it periodically with the patient, in an attempt to detect improvement, worsening, the course of the illness, and early signs of relapse. There are a lot of causes that could bring the patient to psychiatric advice; these include:

- Cognitive impairment (e.g., disturbed consciousness, memory impairment etc.).
- Substance abuse or dependence.
- Mood changes.
- Thought disorders.
- Perceptual disturbances.
- Behavioral disorders.
- Physical complaints or anxiety about illness.
- Sexual problems.
- Eating problems.
- Sleeping problems.
- Problems with impulse control.
- Adjustment problems.

The patients should be asked about any of those topics, if he did not give spontaneous information about it.

History of present illness

The history of the present illness should elucidate the manner in which the patient's symptoms have developed; in particular, how they have influenced and been influenced by the environment from the time they first began.

It is desirable to begin by determining **when the symptoms began**. When this is difficult, the patients are urged to come back to a time when they are symptom free and to describe what has happened to them since then.

The history of the present illness should elucidate **how** the patient's symptoms have developed; is it sudden, gradual or insidious, is there any **precipitating factor** and its importance in the causation of the disorder. It is important to determine if the patient's symptoms are progressing, static, or remitting. Also, it is useful to know if symptoms are intermittent or continuous (**course**). The effect of the illness on the patient's social, occupational or academic functioning should be determined. Also, the results of previous treatment trials (type, dosage, and duration) should be documented.

The patient should know that, no matter what he has to report, the psychiatrist, in contrast to his family or friends, will listen uncritically and will not argue or attempt to deny the perceptions of events, or ridicule for reporting strange ideas.

Evaluation of the presence of stressors (precipitating factors):

Some patients directly relate their difficulties to psychosocial stresses; family, work, financial, legal, or health problems. Here the physician's task is to define the exact nature of the stress and how it has influenced the patient. Other patients do not believe that their symptoms are related psychosocial stresses even when the relationships are obvious. The clinician should consider that the patient's perceptions are correct, or on the contrary, that the patient is incorrectly attributing symptoms to stress.

Past psychiatric history:

The past history reveals a picture of the patient's life experiences and behavior from birth to the present. Not all of this information is relevant to diagnosis. Some experiences may be necessary or sufficient causes of current symptomatology, other experiences may foster the development of personality traits that influence the manner in which the patient deals with symptomatology and is influenced by treatment.

Past psychiatric disorders and drug dependence are recorded stressing on its age of on onset, duration and treatment received and response to treatment.

Evaluation of medical history:

Information about past medical history may show "how patients view their pat illness, how the illness interfered with their usual activities, how the illness influenced the environment, and how they the illness may have influenced the patient's development".

Current nonpsychiatric illness may have either an indirect or direct relationship to the patient's psychiatric symptoms.

Personal History

In developing information about how the past history is relevant to the present symptomatology, it is useful for the clinician to make three general types of inquiries:

1. How did certain characteristics of the past environment adversely influence the patient?
2. How did certain characteristics of the patient interfere with his or her capacity to meet environmental expectations?
3. How has the environment responded to the patient's deficiencies?

1. Early development: it is important in cases of children.

- Attitudes of the parents toward the child at the time of conception and whether the child was wanted on not.
- Diseases, medication use, or trauma during pregnancy.
- Type of delivery and presence of complications during it; was there any evidence of injury or birth defect at birth.
- Milestones of development (date of crawling, walking, talking and sphincter control).
- Diseases of childhood: serious diseases especially that affecting the central

nervous system.

- Feeding habits: breast or bottle-feeding, eating problems.
- Toilet training: age, attitude of parents, feelings about it.

2. Neurotic traits during childhood

e.g., Thumb sucking, nail-biting, childhood fears, bed wetting, stammering, sleep talk and sleep walk, nightmares and night terrors.

Now: The significance of Neurotic traits is doubtful, none of them by itself is of pathological significance, and there is no evidence that these behaviors in childhood are precursors of neurosis in adulthood and there is no reason to think that adult neurosis can be prevented by treating these problems in childhood.

3. School history:

Knowledge of the patient's past intellectual achievements gives an idea about the patient's intelligence, and allows the comparison with the patient's current level of intellectual functioning, e.g., a college graduate who has difficulties in dealing with simple abstraction is likely to have severe impairment. A similar finding may have less clinical significance in those with limited education. It is important to inquire about:

- Age of beginning and type of school (regular or special school).
- Adjustment to school:
  1. Relationships with peers & teachers.
  2. Favorite studies or interests, particular abilities or assets, extracurricular activities, sports, and hobbies.
- How far the patient progressed and what is the highest level of academic performance, and how far other members of the patient's family go in school and how does this go with the patient progression.
- What is the patient attitude toward academic achievement?
- Abnormal behavior; e.g., truancy, stealing, bullying.

Causes of difficulties of academic achievement

1) Low intelligence.
2) Social problems: child occupied in helping his family and has no time to study.
3) Physical problems: chronic or recurrent acute physical diseases.
4) Mental illness e.g. schizophrenia, chronic or recurrent depression or mania.

4. Occupational history.

It is useful to go through the patient's entire work history from first job to the present. When time is limited, it may be more practical to ask what jobs has the patient worked for the longest period of time and to focus on the patient's current occupation.

In either case the clinician should try to determine the status of patient's jobs, the degree of success at work, and if the amount of energy needed in their work are static,

decreasing or increasing. Even if no change in job performance it is useful to enquire if it is getting more physically or intellectually difficult. Either upward or downward occupational mobility can be stressful. Reviewing the exact skills that are needed in the patient's current employment help the physician to learn about various aspects of the patient's motor, social and cognitive skills.

High level of job satisfaction helps patients to deal with mental illness. Low level of satisfaction may be a causative or complicating factor. Job satisfaction is determined by monetary rewards, the enjoyment of the work itself, and the quality of interpersonal experiences available on the job.

Stresses associated with the work environment may have deleterious effect on the patient health (noise, chemicals).

Finally, it is to be noted that, even severely disturbed patient may quite well at work, they find work the only satisfying aspect of their lives. The presence of a positive work situation may be a critical factor in clinician decision about to hospitalize the patient or not.

5. Sexual history:

Though, the significant change in attitude about sex in recent years, the physician should be aware of the danger of embarrassing the patient the patient in the course of taking sexual history. Questions should be asked tactfully, and answers should be handled in the same way.

So, in the early phase of evaluation a detailed assessment of sexual history is not needed unless the patient complain sexual dysfunction or are involved in a type of sexual behavior that troubles them or others. In patients who reports no sexual difficulties, the effort to take history of past sexual experiences may not provide sufficient diagnostic or therapeutic information to justify the invasion of privacy and the possible loss of rapport that it may produce.

The following items are to be obtained in taking sexual history:

1) Onset of puberty, feelings about it, kind of preparation, development of secondary sex character.
2) Adolescent sexual activity: dating, masturbation, nocturnal emissions, and attitudes toward them.
3) Attitudes toward the opposite sex: shy, timid, aggressive, seductive, need to impress, etc.
4) Masturbation: its frequency, associated fantasy, objects used (if any). Also it is important to ask about misinformation about masturbation like, its hazards on physical health or being unforgivable sin etc. This should be asked even in married individuals since it sometimes practiced in married people. Females need tactful inquiry about this topic.
5) In patients with sexual dysfunction, an elaborate past history is required. The clinician begins by determining if the major problem is lack of interest in sexual activity with available partner, or if the patient has a sexual desire but unable to perform sexual intercourse satisfactorily.
6) The issue of patient's sexual preference may be obvious early in the interview. No matter how comfortable patients may be with their

homosexual orientation at present, it is safe to assume it has caused them some painful moments in the past. Every homosexual must go through the process of realizing that his or her sexual preferences are different from those of his or here peers and is forced to deal with many stresses that societies put on homosexual. Adjustment to homosexual preferences influences other aspects of the patient's life and may be to the current symptomatology.

7) A final issue to be considered in taking sexual history is the possibility that the patient has deviant sexual interests (e.g., fetishism).

6. Menstrual history: is useful in some patients

a) Age of menarche, how the patient first learns about menstruation, attitudes to periods, regularity, amount, dysmenorrhea and premenstrual tension.

b) Age of menopause and any symptoms at that time.

c) Date of last menstrual period.

N.B.: Unexpected onset of periods in an unprepared girl could give rise to lasting anxiety.

7. Military history:

Military service is a unique environment for most people; in some ways it is to be more stressful. Military service requires adjustment to a new geographical region while separated from the family and friends. It requires the capacity to live with very little privacy and in close proximity to members of the same sex, and the ability to adjust to a hierarchical culture in which one must submit to authority.

The military history reveals something about the patient's personality traits. It is always useful to inquire about how successfully the patient accommodated to military life and to obtain information about various military experiences. The rapidity with which the patient advanced in rank provides a good index of the quality of their military adjustment.

Inquiries about disciplinary problems provide a clue about antisociality. Special attention should be given to combat experiences and their subsequent impact on the patient. Also, it is useful to enquire about physical and mental problems that developed during the service and whether they have been adjudicated as having service-connected disability.

8. Marital history

The history of marriage provides a picture of what are usually the most important relationships of patient's adult lives. Thus it tells a great deal about patient's personality traits and their stresses, their vulnerabilities, and their pattern of learning during adulthood. The circumstances of marriage, the length of marriage, the presence of children and their ages are essential information. There are certain areas that are especially important include:

a) Age of patient at marriage.

b) Spouse: age, occupation, health, personality.

c) Type of marriage

- Love marriage "choice of the two partners after mutual attraction",
- Arranged marriage "the partners agree about the proposal suggested by a family member or a friend"
- Forced marriage "which is accomplished against the well of one or both partners" marriage"
- Business marriage "the partners agree to marry to obtain certain benefit"

d) The quality of communication within the marriage:

Marriage provides the opportunity to discuss feelings and problems with a loved empathic person. Ideally, marital partner should be able to discuss freely with one another almost anything, particularly their feelings about one another.

Patterns of communication could be revealed by asking the patient directly about them or by observing the patient interaction with his or her spouse. As the patient reveals feelings such as anger, or fear, it is appropriate to ask "have you shared this with your spouse?" if the patient answers negatively, the physician should inquire, "why not" the answers of these questions are likely to clarify the limitation of communication that characterizes the marriage.

e) The quality and frequency of sexual relationships:

Changes in the quality or frequency of sexual activity may be associated with a mental or physical disorder, or with problems in the marriage such as conflicts or shifts in power with the relationship.

Many men accept the idea of equality between sexes intellectually but still find it difficult to deal the reality of a wife's being assertive or, perhaps, being the main breadwinner. This may have a negative impact on their sexual interest and performance. Women who feel that they being committed to what they view as the low status role of homemaker may similarly resent their husbands' success in business, service, or academic career. Such resentment may be expressed as a loss of sexuality.

f) The quality of friendship between marital partners:

Some patients consider their spouses their best friend; both their nonsexual and sexual interactions are characterized by a great deal of affection and playfulness. Other patients seem to see their spouses primarily as sex partners, breadwinner, or homemaker; they show little indication of playfulness and tend to focus on their marital obligations or duties rather than their marital pleasures.

Information about this aspect of marriage could be known by asking the patient about "what do you and your spouse like to do together?" or "do you play together very much" or "do you laugh at lot when you are with each other"

g) The capacity of partners to retain separate identities:

In some marital relationships, friendship seems to be based on playfulness or common interest than on a sense on hopelessness and need. It is not uncommon to see couples who show excessive degree of mutual dependency; they cling to one another

for support, and each may be unconvinced of his or her capacity to be free of despair without the other being constantly present and available.

Information about this aspect of marriage could be known by asking the patient about "do you have leisure interests that you pursue without your spouse" or "how do you get along when you and your spouse are separated for several days?".

h) The manner in which the spouse reinforces the patient's illness:

Some patients learn to receive more affection, compassion, and attention from their spouses as a result of their illness. This may lead to reinforcement of the symptoms of their couples, and being resistant to most of treatments. This can only be ameliorated by education of the spouse, usually in the process of marital treatment.

i) The existence of patterns of problems within the marriage:

Although most marriages eventually reach some type of equilibrium in which the two partners' dissatisfaction and gratification are approximately equal. However, there are some marriages in which one partner dominates and takes advantages of the other. It is still common to see marriages in which women are ignored, treated cruelly or harshly, or treated like a property by their husbands. Because of personality difficulties, religious beliefs, or lack of alternatives, these women may continue to endure the marriages. Although, women physical abuse is the most common, it should not be surprising to find male patient who are physically abused by their spouses.

When a patient describe her husband ad domineering, it is useful to inquire if "your husband ever verbally abusive toward you" or "if this dominance is associated with physical violence" or "does he get more nasty during drinking".

j) Patterns of arguments within the marriage:

Some patients insist they never argue with their spouses, a matter that could be true. Sometimes, such statement means that, when they discuss conflicts with one another, the couple tries to mute their anger. When married people never argue, it is usually true that at least one partner is harboring strong resentment toward the other and would prefer a more open relationship. That person may be more susceptible to psychiatric symptomatology.

Arguments can induce acute episodes of anxiety or sadness in one of the participants and can exert a corrosive effect on the marriage. It is usually useful to inquire about the contents of such disagreements, which usually revolve about sex, money, and in-laws. Clinician should inquire about what starts arguments, how long they last, what terminates them, whether they result in violence or reconciliation, and how they affect the participants afterwards.

k) Relationships of patients with their children.

The relationships of patients with their children may be a source of stress or gratification. Raising sick or psychologically difficult child puts great stress on a marriage and increases the risk of psychiatric symptoms and divorce. On the other hand, children may provide hope for the future and for some patients, a reason to stay a live.

The clinician should inquire about the ages and sexes of all children, any difficulties they may have had or are currently having, and the nature of their relationship with their parents.

If the patient had no children, the clinician should ask tactfully about the causes, what is the patient emotional reaction to this?

l) Patterns of family interactions:

The pattern of family interaction may be responsible for distress of one or all of the family members.

9. Habits

Habit: is a fixed pattern of behavior. We ask essentially about risky patterns of behavior like smoking, alcohol drinking, and drug abuse.

10. Personality assessment:

Personality refers to the enduring qualities of an individual shown in his ways of behaving in a wide variety of circumstances. Each patient has his/her own pattern of perceiving, thinking about, or relating to themselves or to others. So, whether or not, a formal personality disorder is diagnosed, all psychiatric patients have personality traits that influence the manner in which they deal with any mental illness they may develop.

Personality traits also influence the development and expression of physical illness, and response to treatment. Personality variables exert a direct influence on how an individual responds to stressful life events. Knowledge of personality traits helps the psychiatrist predict how patients are likely to respond to specific psychiatric disabilities and to specific treatment. The clinician's task in evaluating personality traits is threefold:

1) Description of the present personality traits.
2) Determination the maladaptive traits.
3) Ascertaining how these traits influence the patient's response to any symptoms of mental disorders that may be present.

Evaluation of personality are made by obtaining a history of the patient's past pattern of perceiving, thinking about, or relating to themselves or to others. The maladaptive aspects of such traits can be inferred by inquiring about the patient responded to a variety of past experiences and by noting when these response have not served them well. Consequently, the physician notes whether any maladaptive patterns are detectable or expressed during interview. In determining the impact of personality traits on symptoms, the clinician must explore the manner in which patients perceive, think about, and deal with their disorders.

In evaluating personality, it is useful to evaluate the following:

1. Social relations

a) To others: friendships, few or many (extraverted or introverted), superficial or close, leader or follower, e.g., in a trip, with own or opposite sex. Relations with work-mates and superiors.

b) To family: dependent or independent (e.g. on choosing clothes).

2. Intellectual activities and interests

How does the person spend his leisure time? Leisure time is valued and spent in a variety of ways. The career-oriented persons may have little interest in leisure activity. Leisure may involve activities such as sports,

shopping, watching television, reading, listening to music, working on crafts, home maintenance, building, or just spending time with friends and loved ones.

3. Mood (prevailing affect and mood):

- Normal mood is = appropriate i.e., varies according to situation, happy in good situations and sad in bad situation.
- Stable or fluctuating (swinging)
- Sad, anxious, euphoric.
- Emotional reactions, warm or cold, controlled or demonstrative.

4. Character

The person as described by others (sensitive, reserved, timid, shy, suspicious, jealous, resentful, quarrelsome, irritable, impulsive, selfish, self-centered, self-conscious, lacking in confidence, controlling, dramatizing, self-sacrificing, reclusive, impulsive, dependent, suggestible and good imitator, strict, fussy, rigid, meticulous, proud, aggressive, punctual, excessively tidy, idealistic and over careful, over-conscientious, religious and moral standards, attitudes to the body, health and illness).

5. Energy (behavior)

Describe the energy output in general (generalized Vs. laziness), the pattern of the output of energy (sustainability, periodicity, etc.), and the domains of output. Field of energy output could be intellectual, business, work, social, sportive or otherwise.

- How he spend his time
- In practice: energetic or lazy with easy fatigability
- In fantasy (nature of day dreaming)
- Dreams (their type).

Family history:

Family history includes description of the parents and siblings in the patient's family of origin. Their names, ages, occupations, economic and social status, marital records, and history of mental illness (including suicide), psychiatric hospitalization, mental retardation, epilepsy, drug abuse, and relevant physical illness should be recorded. Evaluation of the pattern of family interaction and parenting style should is of value in many cases.

Studies suggest that most major psychiatric disorders are familial, and that the disposition to psychiatric disorders is genetically transmitted, even though the mode of transmission is unknown.

Mental State Examination

The mental state examination is a cross-sectional view of what the patient thinks, feels and experiences, and behaves, primarily within the environment of the examination itself. Therefore, it deals mainly with the present, not the past.

The examiner should seek information about the patient's general appearance, motor behavior, emotional state, form and content of thought, perception, and cognitive functioning.

Clinicians are advised not to trust their inferences and to test various aspects of mental state. Quite frequently the performance of patients on formal testing yields results than would be suspected from the observation during interview.

I. General appearance and behavior

The physician should evaluate the patient's state of consciousness, manner of relating to examiner, facial expression, posture, dress and grooming, nutrition, health, and personal hygiene.

A) State of Consciousness.

Disturbance of consciousness is classified in various ways; the following is a simple classification:

- **Quantitative lowering of consciousness:** it denotes organic or systemic brain diseases. Consciousness may be considered a continuum from full alertness to coma. It is best assessed by Glasgow Coma Scale.

Glasgow Coma Scale: a well-defined classification of impairment of consciousness; is the. It depends on the patient's best motor and verbal responses as well as eye opening.

Best motor response	1	No movement
	2	Abnormal extension
	3	Abnormal flexion
	4	Withdraws to pain
	5	Localizes to pain
	6	Obeys commands
Best verbal response	1	No sounds
	2	Incomprehensible sounds
	3	Inappropriate
	4	Confused conversation
	5	Oriented and appropriate
Eye opening	1	No eye opening
	2	To pain
	3	To speech
	4	Spontaneous

- **Qualitative changes of consciousness: include many variety e.g.,**
  1. **Trance**: Sleeplike state of reduced consciousness and activity.
  2. **Fugue:** It is a state of clouding of consciousness, combined with an impulse to wander. It occurs in hysteria, depression, and epilepsy.

B) General appearance:

Observations about dress and grooming, facial expression, and an overall impression about the patient are helpful in the diagnosis of some of the clinical syndromes. Obvious physical stigmata and general state of physical health are to be noted.

Dress and grooming; Poor personal hygiene may be a sign of serious mental or physical illness. Depressed or psychotic patients may be too retarded, preoccupied, or perplexed to care adequately for their personal needs. Alcoholics may also present to the emergency room in an unkempt state.

Personal hygiene: Poor personal hygiene may be associated with extreme poverty or the rejection of conventional societal standards, but it may also be a sign of serious mental or physical illness. Depressed or psychotic patients may be too fatigued, preoccupied, or perplexed to care adequately for their personal needs. Alcoholics may also present to the emergency room in an unkempt state.

Facial expression: provides valuable information about mood.

C) Interview behavior (manner):

Evaluating patient's manner of approaching the examination whether they are cooperative, friendly, passive, seductive, or guarded; requires judgment, inference, and observation.

Although assessment of the patient's manner does not provide direct diagnostic clues, it often helps the clinician to confirm the presence of certain personality traits, to gauge the accuracy of the patient's communications, and also, provides clues to the possibility of eminent violence. Surly, suspicious, restless, and uncooperative patients have a higher potential of being violent and should be interviewed with tactful and non-challenging manner.

D) Motor behavior:

The physician routinely observes the patient's gain, involuntary movements, the extent of the patient's movements, abnormal positions.

Motor behavior is assessed by observation. The patient's gait can be observed as the patient's walks in the examination room. Other disorders of movements are noted as the history is taken. More sophisticated evaluations of localized motor dysfunctions are obtained by doing a neurological examination. Disturbances I motor behavior is classified into:

Quantitative disturbance of motor behavior

a **Hyperactivity:** excessive goal directed activity is seen in patients with, hypomania, mania, and ADHD.

b **Psychomotor agitation:** excessive motor activity, that is usually non-purposive and repetitious (e.g., inability to standstill, fidgeting, wringing of hands, pacing, and pulling of clothes) and associated with a feeling of inner

tension. It is present in agitated depression, mania, and some cases of schizophrenia.

c **Excitement:** is an extreme degree of motor hyperactivity that is so intense, frequently continuous and may be dangerous and destructive. It occurs in epilepsy, catatonia, mania, dissociation, and delirium.

d **Psychomotor retardation:** a Generalized reduction of physical or emotional reactions, in which there is lack of initiation and reduction of spontaneous movement. It shows all gradations up to stupor. It is seen in patients with depression, schizophrenia, some frontal lobe syndromes, parkinsonian syndromes and delirium.

Stupor: it is a syndrome characterized by marked reduction or complete loss of motor activity leading to immobility and lack or reduced response to external and internal stimuli without loss of consciousness.

The patient is immobile, mute and unresponsive but appears to be conscious (as the eyes are open and follow external objects. If the eyes are closed, the patient resists attempts to open them). Reflexes are normal and resting posture is maintained, though it may be awkward.

Causes of stupor:

- **Psychiatric disorders:**
  1) Major depressive disorder.
  2) Schizophrenia.
  3) Hysteria: the patient has usually secondary gain, incontinence of urine is rare if ever occur. The patient tends to eat when no one is observing them.
- **Brain lesions**: lesions in the area of 3rd ventricle, diencephalon, upper brain stem, frontal lobe, and basal ganglia may produce a stuporous state in which eyes are open, the patient appear to be alert, reacts slightly to painful stimuli and is uncooperative (akinetic mutism).
- **Petit mal status.**
- **Some metabolic disorders,** e.g., hypercalcemia.

Qualitative disturbance of motor behavior

- **Repetitive movements or acts:**

  a. Tics are repeated, irresistible and purposeless movements that involve a few muscle groups, e.g., blinking and grimacing.

  b. Stereotypy: means aimless monotonous repetition with may be in movements as touching the nose or pacing up and down the room or in speech as repeating some words.

  c. Mannerism: repetition of movements for hours or days, which are keeping with the personality or the illness.

- **Negativism:** means automatic resistance to all stimuli e.g. resistance to passive movements, mutism, retention of urine.

  Some authors define ***negativism*** as doing exactly the opposite of what is

asked, e.g., looking down when asked to look up. ***Resistiveness:*** the patient simply opposes or resists anything he is asked to do e.g. keeping looking straight when asked to look up.

- **Automatic obedience: there is excessive compliance to the instructions given without hesitation and whatever the consequences**

1. **Echopraxia:** spontaneous imitation of actions seen
2. **Echolalia:** spontaneous repetition of words heard
3. **Waxy flexibility:** maintenance of imposed postures however abnormal they may be with prominent absence of fatigue.

- **Catalepsy (posturing):** is a condition characterized by maintenance of posture or physical attitude for a long period of time, e.g., standing beside the door or in the center of the room for long time without apparent reasons. It occurs in organic or psychiatric disorders, or under hypnosis.
- **Catatonia**: is a syndrome characterized by: excitement (agitated purposeless motor activity, uninfluenced by external stimuli), stupor, posturing (voluntary assumption of a rigid posture, held against all efforts to be moved), and waxy flexibility.
- **Involuntary movements (e.g., tremors)** are common in patients taking neuroleptics**.**
- **Impulsive actions:** sudden outbursts of activity with little or no provocation and without consideration of the outcome.
- **Restlessness:** inability to sit or stand for long period.
- **Akathisia:** subjective feeling of muscular tension, which can cause restlessness, pacing, repeated sitting and standing .it s usually due to use of antipsychotic drugs.
- **Aggression:** hostile or angry feelings, thoughts, or actions directed towards an object or person (forceful goal-directed action that may be verbal or physical; the motor counterpart of rage, anger, or hostility).

II. Language and speech:

A) Disorder of the stream of talk

a) **Excessive talk** (**talkativeness**): copious, coherent and logic speech. Rapid speech may reflect cultural patterns, personality traits, or anxious patients. Such patients can usually slow down their rate of speech when asked to do so.

b) **Pressure of talk:** it is excessive spontaneous talking but still perfectly coherent and logical, though there is marked difficulty in stopping the stream of talk, (Difficult to interrupt). It occurs pathologically in mania.

c) **Slowing of the stream of talk:** Slow speech may reflect cultural patterns, personality traits, extreme cautiousness, or impaired ability to think at a normal rate (e.g., in depressed patients and in those with altered consciousness). Slowing of speech shows different degrees:

- Lack of spontaneous talk.
- Delayed response to questions.
- Short response to questions.
- No response to questions in cases with mutism

B) Language and speech abnormalities:

a) Aphasia: refers to a disturbance of language that is not caused by motor abnormalities of speech or articulation. It is manifested by linguistic dysfunction in the form of defective syntax, defective comprehension, or a loss of the capacity to choose words.

b) Dysarthria: an abnormality in articulation.

Causes of dysarthria:

1. Cerebral lesion:
2. Cerebellar lesion:
3. Brainstem lesion: structural compromise of the corticobulbar tracts (unilaterally or bilaterally) or cranial nerve nuclei V, VII, X, XII lesions. The most common diseases that cause this are stroke, tumor, demyelinating diseases, motor neuron disease, and collagen disease.
4. Cranial verve lesion: cranial nerves V, VII, X, XII lesions. The most common diseases that cause this are collagen disease, viral infection, diabetes, and alcohol.

c) Aphonia and Dysphonia: are abnormalities in phonation. In aphonia there loss of the ability to vocalize; the patient talks only in whisper. In dysphonia, there is impairment with hoarseness, but without complete loss of function. It occurs with paralysis of the 9the cranial nerve or with disease of the vocal cords, or in hysterical aphonia.

III. Affect:

Whenever the patient experience emotional disturbance, it is essential to know how that emotion is experienced, what it feels like, how severe it is perceived to be, how long it lasts, what brings it on, and what relieves it. It is critical to know that it is difficult to learn much about emotionality without considering the patient's history.

In evaluating emotionality, the physician's major problem is trying to identify a private experience precisely. One begins by asking the patient to describe the experience. One then may try to help the patient be more detailed and precise by suggesting descriptive adjectives (intolerable, frightening) or sometimes metaphors.

If the patients are mute or communicate little, their emotionality is inferred from on the basis of recent history, general appearance or motor behavior. Associated symptoms may help ascertaining emotionality e.g., insomnia, anorexia, and withdrawal from activity in depression. Also the content of the patients thoughts may help in understanding their feelings e.g., depressed patients report thoughts that revolve round guilt, loss, and hopelessness.

An important issue in assessing emotionality is the reliability of patient's descriptions of their experiences. Some patients cannot describe their feelings very well, and often they describe their theme inaccurately. Here the clinician must use

empathic skills and ask questions like " does it fee as if you want to cry" or do you feel a sense of impending doom" to help patients identify the exact nature of their emotions.

Mood should be assessed for:

- Quality / type: elevated, depressed, irritable, anxious, emotionally cold.
- Quantity / range: average, exaggerated, restricted.
- Stability: stable, fluctuating, with diurnal variation.
- Congruence with affect.
- Congruence with thinking (delusions).

Disturbances of affect can be classified into:

I) *Quantitative disturbances*

A) Pleasurable affect

1. **Elation:** it refers to excessive happiness. It is pathological when out of accord with the patient's actual circumstances.

2. **Euphoria**: is a generalized sense of well being (not amounting to a definite affect of gladness)

3. **exaltation :** it is feeling of happiness associated with grandeur.

4. **Ecstasy**: Is a feeling of happiness with mystical coloring.

B) Unpleasurable affect

1. **Sadness:** sense of unhappiness that occur as a reaction to loss of loved persons, money or status.

2. **Depression:** is a feeling of sadness out of accord with the patient's actual circumstances.

3. **Anxiety:** Feeling of diffuse unpleasant vague sense of apprehension, tension, or uneasiness due to anticipation of danger, the source of which is largely unknown or unrecognized. This is in distinction to fear, which is the emotional response to a threat that is known, external and well defined. It is often accompanied by autonomic symptoms.

4. **Irritability**: emotional response elicited with undue readiness, i.e. easy provocation.

5. **Phobia** is a persistent irrational fear in the presence of or anticipation of a specific object or situation, that result in conscious avoidance of the feared object, activity or situation. Either the presence of or the anticipation of the phobic entity elicits immediate anxiety response or panic attack in the affected person (anticipatory anxiety) who recognizes that the reaction is excessive. The phobic stimulus is avoided or endured with marked distress.

6. **Panic attacks:** are relatively short lived periods (usually less than one hour) of abrupt intense fear or discomfort that reach peak within 10 minute, which are accompanied by autonomic symptoms as palpitation and tachypnea with sense of impending death. It is accompanied by abrupt onset of a variety of symptoms and fears including, fear of going crazy, or losing control,

shortness of breath or smothering sensation, dizziness, faintness, or feelings of unsteadiness, tremors, sweating, nausea or abdominal distress, flushes, or chills, and chest pain or discomfort.

7. **Blunting**: lack of emotional expression.
8. **Apathy**: Absence of affective expression and experience.

II) *Qualitative disturbances.*

1. **Incongruity or disharmony:** inappropriateness of affect to both thought content, and actions or events that are going at that time. For example, one feels happy while he believes that he will be killed by his enemies, or smiling or assuming a silly facial expression while talking about a serious or sad subject. Such incongruity must be distinguished from laughter indicating that someone is anxious when talking about a distressing or uncomfortable topic.

2. **Ambivalence:** simultaneous existence of contradictory emotions (love and hate) or ideas (present and absent at same time). Thus incompatible emotions and desires coexist at the same moment. Bleuler considered it as one of the fundamental symptoms of schizophrenia.

3. **Lability:** sudden short lived but often intense changes in feeling may occur in response to minor events or no apparent cause. It is encountered in a variety of organic brain disorders such as cerebral atherosclerosis (pseudo-bulbar syndrome).

IV.Thinking

Thinking abnormalities may include disturbance in the form, stream or content of thinking.

1) Formal thought disorders:

The way in which the person puts ideas and associations i.e., the process of thinking. It is assessed by coherence of speech and the way in which mental associations are made.

- **Loosening of associations:** the flow of thought in which ideas shift from one subject to another in a completely unrelated way; when severe, speech may be incoherent. Words or phrases do not seem to be meaningfully connected; the connection between associations can not be ascertained. There are varying degrees of severity of loosening of associations. There are many variation of loosening of association, e.g.,
  - **Derailment:** Gradual or sudden deviation in train of thought.
  - **Clang association:** associations are made by the sound of words rather than by the meaning of words. For example, “I went to the house, the mouse and louse bit me”, (words have no logical connection).
  - **Flight of ideas:** The stream of talk is rapid, continuous, but the ideas are frequently changed. The talk becomes fragmentary, the connections being determined by chance associations between the fragments e.g. the meaning of the last word) or by chance stimuli from the environment (distractibility). Rhymes and other sorts of word play and jokes are common. Speech may become disorganized and incoherent, but syntax and vocabulary are usually intact.

- **Tangentiality:** is a manner of speech in which, initially, ideas seem related, but in which patients go off in unrelated directions and never reach their goal. In its mildest form, the tangent may have some detectable relationship to the original idea.
- **Circumstantiality:** the patient follows side issues before reaching its goals. A patient gives unnecessary details and inappropriate thoughts before reaching the central idea. It is seen in major and minor illnesses. It is seen in obsessive patients, in bipolar disorder. In elderly it is seen as a sign of organicity, but this is not always true.
- **Irrelevant answer** to questions.
- **Thought block:** the stream of talk stops for a while for which the patient can not explain. The patient resumes talking in another topic, and do not recall of what was being said or was going to be said. It occur in schizophrenia and organic brain syndromes.
- **Perseveration**: repetitive use of stock words or phrases, *even when these* words do not enhance the meaning of communication. It may be culturally determined e.g., the use of the phrase "you know", but if the continually repeat phrases in a nonconventional manner, it is usually described as speech perseveration. Repetitive use of stock phrases is often associated with organic brain syndromes.
- **Use of idiosyncratic language:** patients may create words that do not exist in dictionary and use them as substitutes for conventional words (neologism).

2) Abnormal thought contents include:

1. Overvalued ideas: false beliefs less firmly held than delusions.
2. Delusions.
3. Obsessions.

Delusions:

A delusion: is fixed false belief that cannot be corrected by logic and reasoning and is not accepted by persons of the same cultural and educational standard.

Delusions are classified in various ways:

1. **Bizarre or not:** bizarre delusions can not occur in real life; like being influenced by satellite, thought withdrawal or insertion. It is characteristic of schizophrenia
2. **Mood congruent versus mood -non congruent** based on whether delusions are going with the patient mood or not.
3. **According to the theme of delusion:**

a **Delusion of control (influence)**: False belief that a person's will, thoughts, or feelings are being controlled by external forces.

b **Delusion of grandeur**: Exaggerated conception of one's importance, power, or identity.

c **Delusion of infidelity**: False belief that one's lover is unfaithful. Sometimes called pathological jealousy.

d **Delusion of persecution**: False belief of being annoyed, worried or followed by others.

e **Delusion of poverty**: False belief that one is poor or will be deprived of all material possessions.

f **Delusion of reference**: False belief that the behavior of others refers to oneself; (e.g., belief that people on television or radio are talking to or about the person).

g **Delusion of self-reproach**: False feeling of remorse and guilt. Seen in depression with psychotic features.

h **Nihilistic delusion:** false belief that one's body or parts of it is disintegrating or lost, e.g., he has no intestines or that he is dead.

i **Hypochondriacal delusions:** the patient is convinced that he has a physical disease in the absence of any evidence of physical illness.

j **Delusion of infestation:** the patient believes that he was infested with small but macroscopic organisms e.g., parasites, spiders, and lice. It occurs in schizophrenia, organic and toxic states.

k **Erotomania (amorous delusions)**: delusional belief, more common in women than in men, that someone is deeply in love with them, usually inaccessible, of higher social status, and someone to whom she has never spoken to him.

l **Delusions concerning the possession of thought :**

1. **Thought insertion**: the subject believes that thoughts are implanted into his mind by other people or forces.
2. **Thought withdrawal:** the subject believes that ideas are taken away from his mind by other people or forces.
3. **Thought reading:** the subject believes that other persons could read his mind or know his thoughts. It is not merely that others guess their secrete thoughts from their words, actions, or facial expression, but that the thoughts are directly available and can be, in a real sense, read by others.
4. **Thought broadcasting (audible thoughts):** delusion that one's thoughts leave him and diffuse widely out of his control. The subject believes that his thoughts are broadcast so that he or others can hear them. Sometimes the subject feels his thoughts are being broadcast, although he can not hear them himself..

Obsessional and compulsive symptoms

Obsessional and compulsive symptoms are best described separately although they often occur together.

A) Obsession:

1. A feeling of compulsion to repeat some mental or physical act.
2. Which the patient resists.
3. Recognizing that it is absurd and meaningless.

TYPES (forms) of obsessions:

A) **Obsessional thoughts:** are repeated and intrusive words or phrases, which are usually upsetting to the patient; e.g. repeated obscenities or blasphemous phrases coming into the awareness of a religious person.

B) **Obsessional ruminations:** are repeated worrying themes of a more complex kind e.g. about the ending of the world.

D) **Obsessional impulses:** are repeated impulses to carry out actions that are aggressive, dangerous, or socially embarrassing, e.g. the urge to pick up a knife and stab another person or to jump in front of a train.

Although the themes of obsession are various, most can be grouped into one or other of six categories:

1. **Thoughts about dirt and contamination**: are usually associated with idea of harming others through the spread of disease.

2. **Aggressive thoughts**: may be about striking another person or shouting angry or obscene remarks in public.

3. **Thoughts about orderliness**: may be about the way objects are to be arranged or work to be organized.

4. **Thoughts about illness:** are usually of a fearful kind; e.g., a fear of cancer or venereal disease. This fearfulness has resulted in the name illness phobia, but the term should be avoided because the phenomena are not examples of anxiety arising in specific situations, (which is the hallmark of phobia).

6. **Obsessions about religion:** often take the form of doubt about fundamentals of belief (e.g., does God exist?) or repeated doubts whether sins have been adequately confessed (scruples).

B) Compulsions:

Are repetitive and seemingly purposeful behaviors, performed in a stereotyped way (hence the alternative name of compulsive rituals). They are accompanied by a subjective sense that they must be carried out and by an urge to resist, and are recognized by the patient as senseless. A compulsion is usually associated with an obsession as if it has the function of reducing the distress caused by the latter, e.g. a hand washing compulsion often follows obsessional thoughts that the hands are contaminated. Occasionally, however, the only associated obsession is an urge to carry out the compulsive act. Compulsive acts are of many kinds, but the following kinds are particularly common:

1. **Checking rituals**: are often concerned with safety (e.g. checking over and over again that a gas tap has been turned off).

1. **Cleaning rituals:** often take the form of repeated hand washing but may also involve household cleaning.

- **Counting rituals**: may be spoken aloud or rehearsed silently. They often involve counting in a special way, e.g. in threes, and are often associated with doubting thoughts such that the count must be repeated to make sure it was carried out adequately.
- **Dressing rituals**: the person has to lay out his clothes in a particular way, or put them in a special order. The rituals is usually associated with doubting thoughts that lead to seemingly endless repetition.
- ***Obsessional slowness:*** is usually the result of compulsive rituals or repeated doubts but it can occur occasionally without them (primary obsessional slowness).

Suicidal and homicidal ideas

It is essential to assess the degree of the patient's dangerousness on self and others. Risk factors include the presence of a plan, tools and its seriousness and the degree of intent, and the possible protecting factors.

The assessment of suicide risk is one of the most important and difficult tasks in psychiatry. Since suicide is preventable, the importance of good prediction and timely intervention is obvious. It is advisable to take all suicidal threats seriously even they seem manipulative. Patients with a history of frequent accidents should be asked about life problems, drug and alcohol use, depression and self-destructive feelings.

V. Perceptual disorders:

Perception is the process of becoming aware of what is presented through the sense organs.

Disorders of perception:

A- Hallucinations.

Hallucinations are false perceptions without an external stimulus.

Classification and types of hallucinations:

A) According to sensory modality:

i. **Auditory hallucination:** false perception of sounds usually voices, but other sounds, such as ill defined sounds or music may be heard. Auditory hallucination may take the form of;

- **Second person hallucinations** (appear to address to the patient e.g., you are going to die, give commands e.g., hit him, or comment on his behavior e.g., you are wrong. In themselves they do not point to a particular diagnosis, but their content and especially the patient's reaction may do so, e.g., voices with deprecating or insulting contents suggest depressive disorder, especially when the patient accepts them as justified, e.g., "you are wicked". In schizophrenia the patient more often resents such comments),

- **Third person hallucination** (voices which appear to be talking to each other, referring to the patient as he or she e.g., he is a homosexual).

ii. **Visual hallucination:** false perception involving sight consisting of both formed (complex) images e.g. people and ill-defined (elementary) images and colors e.g. flashes of light. They may appear normal or abnormal in size; if the latter, they are more often smaller than the corresponding real percept (sometimes called Lilliputian).

It may occur in drug intoxication, severe affective disorders, and schizophrenia, but it should raise the possibility of an organic disorder. The content of visual hallucinations is of little diagnostic significance.

iii. **Olfactory hallucination:** false perception of smell usually experienced as unpleasant smell. They may occur in schizophrenia or severe depressive disorders, but

they should also suggest temporal lobe epilepsy or irritation of the olfactory bulb or pathways by a tumor.

iv. **Gustatory hallucination:** false perception of taste such as unpleasant taste caused by an temporal lobe seizure usually experienced as unpleasant taste.

v. **Tactile hallucination:** false perception of touch or surface sensation. They may be experienced as sensations of being touched, held, hit, pricked, or strangled. They may also be felt as movements just below the skin, which the patient may attribute to insects, worms, or other small creatures burrowing through the tissues (formication). In cocaine psychosis this type of hallucination usually occurs together with delusions of persecution and is known as "cocaine bugs".

Tactile hallucination may take sexual coloring to form what is called sexual hallucination, e.g., orgasm or erection forced on males, and rape or sexual abuse with females. It usually suggests schizophrenia especially if interpreted in an unusual way e.g. resulting from intercourse with a series of persecutors.

vi. **Somatic hallucinations** (Visceral hallucinations, Cenesthetic hallucination): peculiar sensations, which are not perceived under appropriate physiological conditions in or to the body organs, most often visceral in origin. For example, feeling of electricity running through one's body, burning sensation in the brain, or flowing of blood inside blood vessels.

***B)* According to relation to emotional state: hallucination is classified as either Mood congruent or Mood incongruent. This depends on whether the contents of hallucinations are going with the patient's mood or not, e.g., in depression the patient may hear voices that disregard and humiliate him.**

Reaction to hallucinations:

1. **Astonishment;** this is usually so with genuine hallucinations and in early psychosis where insight is still preserved and critical attitude to the starting experience is coloring the picture.
2. **Anger;** when the patient the hallucinatory voices or figures as enemies.
3. **Terror;** may be a reaction to a hallucinatory threat or a reaction to the experience of change in self in early psychosis.
4. **Conversation;** more with images than hallucinations.
5. **Habituation**; the hallucination persists the more it becomes a part of the patient life.
6. **Welcome;** in chronic cases of schizophrenia, hallucinations form part of the personality and become indispensable.
7. **Obedience;** this is associated with passivity phenomenon.
8. **Resistance;** this is another form of resentment which is less than anger, however it could denote some sort of insight into the hallucinatory experience.

Diagnostic guideline:

A) Organic hallucinations; always occur in clouded consciousness, are mostly visual, accompanied by fear and have an acute onset and rapid course. They could be

understood to arise from diminished awareness and apprehension.

B) Schizophrenia: hallucinations always occur in clear consciousness, are mostly auditory, typically discussing the patient in the third person, commenting on his acts repeating his thoughts or calling his name they have an insidious onset and prolonged course. They can not be understood as arising from other mental mechanisms.

C) Depressive disorders: The contents of depressive hallucinations are understandable as arising from the depressive mood or the sense of guilt. Hallucinations may be accusatory voices, scenes of deaths, or somatic or bodily changes. The patient accepts them because they relieve his sense of guilt.

Causes of hallucinations:

1. Hypnagogic and hypnopompic hallucinations occur when going to sleep or awakening from sleep respectively, they are considered normal.
2. Psychotic disorders, e.g., schizophrenia (commonly auditory hallucinations) and psychotic depression
3. Sensory deprivation: blocking or reduction of all incoming stimuli to a minimum in a normal subject usually result in hallucination in those subjects. These hallucinations are usually in the form of visual hallucination and repetitive words and phrases.
4. Intoxication: either accidental (pesticides) or recreation substances (e.g., LSD).
5. Organic conditions, e.g.,
   - Metabolic encephalopathy, e.g., hepatic encephalopathy.
   - Febrile illness, e.g., typhoid.
   - Brain diseases e.g., encephalitis and brain tumors.
   - Epilepsy.

B- Illusions:

Illusions means misinterpretations of real a stimulus, e.g., in a dark room one perceive a rope as a snake. It may be caused by:

- Expectations may facilitate the occurrence of illusions, e.g., if someone is waiting an important telephone call he may perceive ringing of the bell of the door as a telephone ring.

- Intense emotions: a person who is afraid may perceive benign objects as terrifying.
- Impaired consciousness may be associated with illusions especially acute causes, e.g., alcohol intoxication or withdrawal.
- Epilepsy: aura or psychomotor epilepsy may present with illusions of familiarity or unfamiliarity.

VI.Orientation

Orientation is the capacity to determine accurately one's temporal, spatial and personal relations at the present moment. So we examine orientation for:

A) Time →hour, day, month, and year.

B) Place → city, state, hospital, floor of the building.

C) Person → who are those surrounding you?

Though it is better to evaluate cognitive function in one block rather than being interspersed throughout the interview, testing orientation is sometimes an exception. Disoriented patients are likely to have difficulty in providing accurate information throughout the interview. The sooner the examiner knows about this deficit the more accurately he will be able to fine tune questions to the patient's capabilities and to gauge the reliability of the patient's answers.

Disordered orientation is caused by all causes of organic brain diseases, either acute or chronic, metabolic disorders, acute systemic infections. However, it is to be noted that disorientation can occur without organic brain disease; it may be present in situations where the patient lacks the access to sensory cues that is required for orientation (e.g., inpatients admitted for long periods may be unaware of the precise date, as they have no need of such awareness. Patients with disturbed consciousness who awake in the hospital after an accident will initially be disoriented about place and person till provided with oriented information).

VII. Memory

Memory impairments even if minor are generally distressing to patients. People become uncomfortable when they can not remember the names of friends and relatives. If they forget where they have parked their car, they may become extremely upset. Subjective distress over memory impairment is not always communicated to the physician. Often, the patient who is so suffering tries to hide his painful reality from family, friends, and the physician. Important exception is the seriously depressed patient who may exaggerate the degree of memory impairment.

We examine memory as follow:

- **Immediate recall;** recall of perceived materials after 5-10 seconds. It is examined by repetition of letters, numbers, or four unrelated words (brown, honesty, tulip, and eyedropper) or three-line address. *It is unlikely to be impaired in psychiatric patients, and it does not have to be formally tested. It manifests itself from the beginning of the interview in the patient's inability to respond to the examiner's questions.*

- **Short term memory:** is the ability to recall information after 5-10 minutes, usually tested after distraction between presentation and recall: ask the patient to repeat four unrelated words (brown, honesty, tulip, and eyedropper) and recall them after 10 minutes. Norm equals 3-4 words for normal adults before age 60. Asking the patient to repeat a series of numbers. The patient should be able to recall and recite at least 7 numbers forward and 5 numbers backward. Also, recall of a story or an address after 5-10 minutes. The patient is instructed to pay attention to a short story, the then the story is read slowly. *It can be tested by asking the patient to remember three or four items after 5 minutes. In more formalized testing standardized pairs of words are taught to the patient, and few minutes later they are asked about which word should be paired.*

- **Recent memory:** recall of events that occurred 30 minutes to days preceding the evaluation. *It is tested by asking the patients about events in the previous 24 hours either personal or environmental events; or* he is asked to recall the four words, after 30 minutes.

- **Long term memory:** events that happened years ago. Deficits in long term memory become apparent in the course of history taking, if the patient become regularly confused about time consequences. Here it may be useful to inquire about specific events in the patient's life, such as birth and marriage dates.

Structured evaluation of memory could be done using special tests such as Wechsler memory scale.

Disorders of memory are commonly divided into: Hypermnesia, Amnesia, and Dysmnesia.

1) **Hypermnesia**: sharp memory; patient mention even small unnecessary details; occurs in prodigies in mania and paranoid disorders.

2) **Amnesia** → is loss of memory which may be partial or complete:

Types of amnesia.

A) ***Anterograde amnesia*** → loss of memory for events occurring after a point of time, e.g., inability to recall events between the end of complete unconsciousness and the restoration of full consciousness in a case of head trauma.

B) ***Retrograde amnesia*:** loss of memory for events occurring before a point of time, e.g., inability to recall events before the onset of unconsciousness in a case of head trauma.

C) ***Total amnesia*** → loss of memory for recent and remote events

D) ***Circumscribed amnesia*** → loss of memory for a limited period (amnesic gap).

Causes of amnesia:

- **Cognitive disorders,** e.g., dementia of the Alzheimer's type.
- **Head trauma.**
- **Epilepsy.**
- **Electroconvulsive Therapy.**
- **Psychiatric causes:**

  A] Dissociative disorders, such as fuge, dissociative amnesia, and dissociative identity disorder.

  - **Fuge** is a dissociative disorder characterized by sudden unexpected travel away from one's customary environment, with inability to recall one's past and assumption of a new identity, which may be partial or complete.
  - **Dissociative amnesia** may be total or circumscribed to a certain events.

  B] Memory difficulties are a frequent complaint in depression and anxiety disorders.

3. Dysmnesia: distortion of memory:

A) Distortion of recall (paramnesia): may be in the form of:

A- Confabulation: this is a detailed false description of a event. The patient gives imaginary accounts of his activities which may be influenced by suggestion. It occurs usually in organic brain syndromes (Korsakov's syndrome), this occurs unconsciously.

B- Retrospective Falsification: the subject modifies his memories according to his general attitudes. The patient adds false details and meaning to a true memory. We all falsify the past to some degree. Excessive retrospective falsification is common in depressive illnesses and histrionic personality. Depressed patient looks back over the past and see only his failures, insist that he was useless or worthless person. Histrionic personalities may produce a complete falsified set of memories of the past. It occurs in organic and psychiatric diseases.

B) Distortion of recognition:

- **De JA vu**: a new situation is incorrectly regarded as a repetition of a previous memory.
- **Ja mais vu**: false feeling of unfamiliarity with a real situation one has experienced.
- **Misidentification**: (it should be distinguished from delusional misidentification)
  - a **Positive:** to recognize strangers as friends or relatives occur in acute confusional state and in schizophrenia.
  - b **Negative:** to recognize friends and relatives as strangers. Capgras syndrome is a form of a negative misidentification.

VIII. Attention and concentration:

Attention: is the ability to focus on a single stimulus and to screen out irrelevant stimuli. Attention is divided into:

a) Voluntary: when the subject focuses his attention on an internal or external event.

b) Involuntary: when the event attracts the subject's attention without his conscious efforts.

Concentration (vigilance): is the ability to maintain attention to environmental cues or tasks over an extended period. It could be affected by various variables including motivation, emotional state, preoccupation with other stimuli, and frontal lobe dysfunction.

Causes of reduced attention and concentration include organic (metabolic disorders, drug intoxication and withdrawal syndromes, frontal lobe dysfunction, CNS or severe systemic infections, hypoxia, postoperative states, electrolyte imbalance), and psychological factors (Low motivation, emotional state, preoccupation with other stimuli, ADHD, severe depression, preoccupation with hallucinations, and severe anxiety).

Assessment: there are a number of traditional means of testing concentration, such as:

I- Repeating the days of the week (commonly used) or the months of the year in a reverse order. The inability to do so shows inattention and impersistence.

II- Serial seven-subtraction test or Serial three-subtraction test tests: ask the patient to subtract 7 from 100 and repeat the subtraction from each remainder (100 – 7 = 93 –7 = 86 – 7 = 79, etc.). *Patients who have difficulty with mathematics may be asked to do simpler mathematical tasks as subtracting serial threes* from 30 *or to perform nonmathematical tasks of concentration as spelling words backwards*. Some claim that normal person should be able to subtract serial seven's without mistakes within ninety seconds.

III- Spell simple words backwards

IX.Evaluation of general knowledge.

Assessment of the extent of the patient's general information about the environment is often a critical factor in determining how successfully they interact with the environment.

This knowledge can be tested by simply asking patients about recent news and events, and running a discussion about it. Usually, only knowledge of recent history is tested; patients are asked about the name of the current president and then to list in the order of their service as many previous presidents as they can. Sometimes, inquires are made about the names of other political figures or other well known historical figures. Geographical knowledge can also be tested e.g., naming state capitals, rivers, or distance between various localities.

X. Intelligence:

In most clinical interviews, intelligence is inferred from the way of adjusting to environment and how he tells his story, rather than tested specifically. The most common ways to do this are through

- ***Stanford Binet test or Wechsler Intelligence Scale*** (for adults or children); it has both verbal and performance scales. Discrepancy between the abilities tested by these two scales is of clinical importance. Organic brain diseases tend to affect performance to a greater extent than verbal scores. The verbal scale is highly sensitive and even the performance scale to some extent is influenced by sociocultural factors.

- ***Evaluation of abstraction***

Abstract thinking includes such psychological processes as forming concepts, categorizing information, generalizing from a single incident, applying procedural rules and general principles, and using metaphors.

Abstract thinking is viewed as a higher cognitive function; accordingly, loss of the capacity to abstract is likely to be one of the first signs of organic brain disease. Patients with impaired higher cognitive function usually demonstrate a kind of thinking that is referred to as concrete.

In the interview, they tend to become stuck on one track and unable to shift their frame of reference as the clinician seeks different levels of information. Loss of abstraction may also be manifest in the inability to relate events to one another during history taking, to assess the importance and meaning o, or to conceptualize aspects of one's interaction with the environment in the earlier phases of one's disturbance.

Abstraction can be tested by tests to detect similarities and differences between various objects, to deal with simple mathematical thought problems, or to interpret proverbs.

1. Testing commonalties or similarities between the following items: an orange and an apple, a bicycle and an airplane, a typewriter and a pencil, a fly and a tree or a statute and a poem.
2. Testing differences between the following items like : a lie and a mistake, or evolution and revolution
3. Answering simple mathematical problems: if pencils are selling at two for ten cents, and if you have 25 cents and want to spend it all on pencils, how many pencils can you buy?
4. Interpretation of proverbs, usually starting with a very simple one as "do not cry on the spilled milk" or "every cloud has a silver lining". If the patient gives appropriate responses to these simple proverbs, more difficult proverbs are given, e.g., "a bird in the hand is worth two on the bush", or "do not putt all your eggs in one basket". If the patient responds correctly, more difficult proverbs are given, e.g., " a rolling stone gathers no moss".

Interpretation of proverbs may tell a great deal about the content of the patient's thinking, not elicited either during history taking or during assessment of thinking.

XI. Insight and judgement:

A. **Insight:** is the amount of realization the patient has of his own condition, i.e., does the patient regards it as an illness or not.

To say that a patient ahs full insight means that:

1. He understands that he is ill.
2. He admits that his illness is due to psychiatric disorder.
3. He admits that, treatment should be through professional help using appropriate scientific information.
4. He accepts contracting about how to get rid of the illness with himself as an active participant.

B. **Judgement:** is one's capacity to evaluate information and to use this knowledge to plan for and deal with life situations. It is frequently retrospectively on the basis of the patient behavior. Patients who act in an inappropriate manner when they seem to have the capacity to do otherwise are often described as having poor judgement.

Tests of judgment in psychiatry focus on one's capacity for prospective planning. The traditional tests of judgment are "what would you do if you found a stamped, addressed, and sealed envelop on the street?" or "what would you do if you were in a crowed theater and were the first person to discover a fire?" However these inquire detect only gross impairments in judgment. More practical information is obtained by focusing on how the patient goes about assessing and planning to deal with real-life problems, which are revealed during history taking especially his/her need for treatment.

From the clinical point of view the patient's opinion about his need for treatment is more beneficial than data about general judgment.

III- Physical Examination

Physical examination is needed to evaluate the patient's general medical (including neurological) status. The scope and intensity necessary will vary according to clinical circumstances. The physical examination includes sections concerning the following;

- General appearance and nutritional status.
- Vital signs.
- Head and neck, heart, lungs, abdomen, and extremities.
- Neurological status, including cranial nerves, motor and sensory function, gait, coordination, muscle tone, reflexes, and involuntary movements.
- Skin, with special attention to any sign of trauma, self-injury, or signs of drug use.
- Any body area or organ system that is specifically mentioned in the history of the present illness or review of systems or that is relevant to determining the current status of problems mentioned in the past medical history.

Importance of physical examination;

An understanding of the patient's general medical condition is important in order to;

- **Determine the patient's need for general medical care.**
- **Choose among psychiatric treatments that can be affected by the patient's general medical status.**
- **Properly assess the patient's psychiatric symptoms and their potential cause.**
  - **Medical disorders as a cause of psychiatric symptom**: neurological, endocrinal, metabolic, collagenic, cardiovascular, and other medical disorders, and their treatments may be responsible a wide variety of psychiatric symptoms and disorders. Usually a physical disorder is not mistaken for a psychiatric disorder. Occasionally however, the medical condition may be preceded by panic, anxiety, or depression. Some clinicians associate delusions and hallucinations with a psychiatric disorder, that they overlook a general medical condition. The incidence of medical diseases producing psychiatric symptoms ranges from 5-42 %.
  - **Psychiatric symptoms as indicator of undetected medical disorder**: this is expected when:

1. When psychiatric symptoms occur in older patients with negative personal and family psychiatric history.
2. When the symptoms occur in unusual combination.
3. When they show an unexpected course.
4. When present at an age for which the onset of the respective psychiatric disorder is rare.

In these cases complete medical and drug, work-up is mandatory to exclude medical conditions and drug as a cause of the disturbance, (10% of psychiatric out patient have unrecognized medical disease producing psychiatric symptom).

- Patients with primary psychiatric illness but presenting with somatic symptoms (40-70 % in medical practice).
- Psychosomatic diseases, e.g., bronchial asthma, rheumatoid arthritis, essential hypertension, thyrotoxicosis and peptic ulcer).
- Mental disorders arising during the course of physical diseases especially serious and chronic physical diseases) (about 80%).
- Those who suffer from the somatic effects of psychiatric treatment.

Best wishes

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