20th Year Edition

SEVENTH EDITION

A Short Textbook of PSYCHIATRY

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JAYPEE

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Chapter 2

Psychiatric History and Examination

Familiarity with the technique of psychiatric assessment is important not only for a psychiatrist but also for a medical practitioner or any mental health professional, since more than one-third of medical patients can present with psychiatric symptoms.

INTERVIEW TECHNIQUE

In no other branch of Medicine is the history taking interview as important as in Psychiatry. All physicians need to communicate with their patients and a skilful interview can clearly help in obtaining better information, making a more accurate diagnosis, establishing a better rapport with patients, and working towards better adherence with management plan.

A psychiatric interview is usually different from the routine medical interview in several ways (Table 2.1). A few important points regarding the interview technique are mentioned below. These serve as pointers towards a technique which clearly has to be mastered over a period of time with repeated examinations.

A consistent scheme should be used each time for recording the interview, although the interview need not (and should not) follow a fixed and rigid method. The interview technique should have flexibility, varying according to appropriate clinical circumstances.

Whenever possible, the patient should be seen first. When the account of historical information given by the patient and the informant(s) is different, it is useful to record them separately.

Table 2.1: Psychiatric vs Medical Interview

A psychiatric interview can be different from a medical interview in several ways, some of which can include:
1. Presence of disturbances in thinking, behaviour and emotions can interfere with meaningful communication
2. Collateral information from significant others can be really important
3. Important to obtain detailed information of personal history and pre-morbid personality
4. Need for more astute observation of patient's behaviour
5. Difficulty in establishing rapport may be encountered more often
6. Patients may lack insight into their illness and may have poor judgement
7. Usually more important to elicit information regarding stressors and social situation

During the interview session(s), the patient should be put at ease and an empathic relationship should be established.

In psychiatric assessment, history taking interview and mental status examination need not always be conducted separately (though they must be recorded individually). During assessment, the interviewer should observe any abnormalities in verbal and non-verbal communication and make note of them.

It is helpful to record patient's responses verbatim rather than only naming the signs (for example, rather than just writing delusion of persecution, it is better to record in addition: "my neighbour is trying to

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poison me"). It is best done in the patient's own spoken language, whenever possible.

It is useful to ask open-ended and non-directive questions (for example, "how are you feeling today"?) rather than asking direct, leading questions (for example, "are you feeling sad at present"?).

Arguably the most important interviewing skills are listening, and demonstrating that you are interested in listening and attending to the patient. It is important to remember that listening is an active, and not a passive, process.

Confidentiality must always be observed. However, in cases of suicidal/homicidal risk and child abuse, an exception may have to be made (see Chapter 20 for details). Patients suffering from psychiatric disorders are usually no more violent than the general population. However, it is important to ensure safety if any risks are apparent.

A comprehensive psychiatric interview often requires more than one session. The psychiatric assessment can be discussed under the following headings.

IDENTIFICATION DATA

It is best to start the interview by obtaining some identification data which may include Name (including aliases and pet names), Age, Sex, Marital status, Education, Occupation, Income, Residential and Office Address(es), Religion, and Socioeconomic background, as appropriate according to the setting. It is useful to record the source of referral of the patient. In medicolegal cases, in addition, two identification marks should also be recorded.

INFORMANTS

Since sometimes the history provided by the patient may be incomplete, due to factors such as absent insight or uncooperativeness, it is important to take the history from patient's relatives or friends who act as informants and sources of collateral information. It is important to take the patient's consent before taking this collateral history unless the patient does not have capacity to consent.

The informants' identification data should be recorded along with their relationship to the patient, whether they stay with the patient or not, and the duration of stay together.

Finally, a comment should be made regarding the reliability of the information provided. The reliability of the information provided by the informants should be assessed on the following parameters:

1. Relationship with patient,
2. Intellectual and observational ability,
3. Familiarity with the patient and length of stay with the patient, and
4. Degree of concern regarding the patient.

The source of referral (such as a letter from patient's general practitioner or a letter of referral from the referring physician/surgeon in case of a liaison psychiatry referral) often provides valuable information regarding the patient's condition.

PRESENTING (CHIEF) COMPLAINTS

The presenting complaints and/or reasons for consultation should be recorded. Both the patient's and the informant's version should be recorded, if relevant. If the patient has no complaints (due to absent insight) this fact should also be noted.

It is important to use patient's own words and to note the duration of each presenting complaint. Some of the additional points which should be noted include:

1. Onset of present illness/symptom.
2. Duration of present illness/symptom.
3. Course of symptoms/illness.
4. Predisposing factors.
5. Precipitating factors (include life stressors).
6. Perpetuating and/or relieving factors.

HISTORY OF PRESENT ILLNESS

When the patient was last well or asymptomatic should be clearly noted. This provides useful information about the onset as well as duration of illness. Establishing the time of onset is really important as it provides clarity about the duration of illness and symptoms. The symptoms of the illness, from the earliest time

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at which a change was noticed (the onset) until the present time, should be narrated chronologically, in a coherent manner.

The presenting (chief) complaints should be expanded. In particular, any disturbances in physiological functions such as sleep, appetite and sexual functioning should be enquired. One should always enquire about the presence of suicidal ideation, ideas of self-harm and ideas of harm to others (see Chapter 19 for details), with details about any possible intent and/or plans.

It is also essential to consider and record any important negative history (such as history of alcohol/drug use in new onset psychosis).

A life chart (Fig. 2.1) provides a valuable display of the course of illness, episodic sequence, polarity (if any), severity, frequency, relationship to stressors, and response to treatment, if any.

PAST PSYCHIATRIC AND MEDICAL HISTORY

Any history of any past psychiatric illness should be obtained. Any past history of having received any psychotropic medication, alcohol and drug abuse or dependence, and psychiatric hospitalisation should be enquired.

A past history of any serious medical or neurological illness, surgical procedure, accident or hospitalisation should be obtained. The nature of treatment received, and allergies, if any, should be ascertained.

A past history of relevant aetiological causes such as head injury, convulsions, unconsciousness, diabetes mellitus, hypertension, coronary artery disease, acute intermittent porphyria, syphilis and HIV positivity (or AIDS) should be explored.

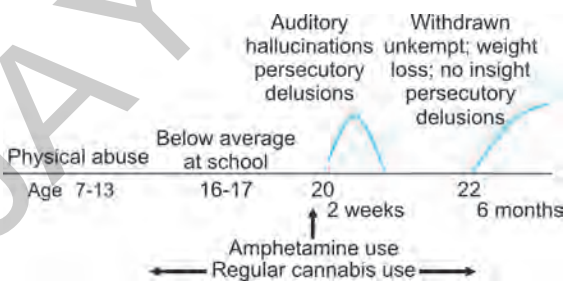


Fig. 2.1: An Example of Life Chart

TREATMENT HISTORY

Any treatment received in present and/or previous episode(s) should be asked along with history of treatment adherence, response to treatment received, any adverse effects experienced or any drug allergies which should be prominently noted in medical records.

FAMILY HISTORY

The family history usually includes the 'family of origin' (i.e. the patient's parents, siblings, grandparents, uncles, etc.). The 'family of procreation' (i.e. the patient's spouse, children and grandchildren) is conventionally recorded under the heading of personal history.

Family history is usually recorded under the following headings:

1. *Family structure:* Drawing of a 'family tree' (pedigree chart) can help in recording all the relevant information in very little space which is easily readable. An example of a typical family tree is given in Figure 2.2. It should be noted whether the family is a nuclear, extended nuclear or joint family. Any consanguineous relationships should be noted. The age and cause of death (if any) of family members should be asked.
2. Family history of similar or other psychiatric illnesses, major medical illnesses, alcohol or drug dependence and suicide (and suicidal attempts) should be recorded.
3. *Current social situation:* Home circumstances, per capita income, socioeconomic status, leader of the family (nominal as well as functional) and current attitudes of family members towards the patient's illness should be noted.

The communication patterns in the family, range of affectivity, cultural and religious values, and social support system, should be enquired about, where relevant.

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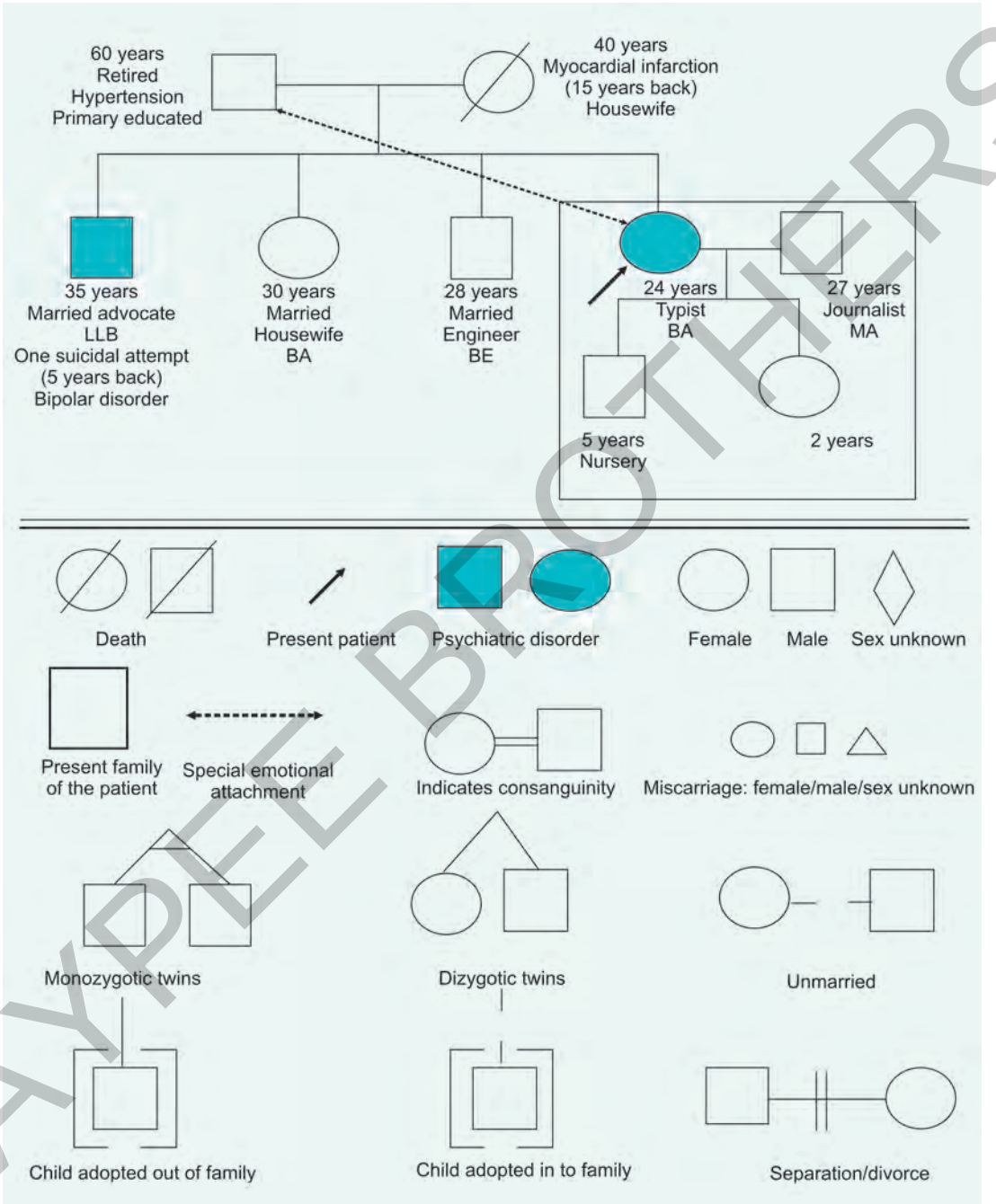


Fig. 2.2: A Typical Family Tree and Common Pedigree Symbols

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PERSONAL AND SOCIAL HISTORY

In a younger patient, it is often possible to give more attention to details regarding earlier personal history. In older patients, it is sometimes harder to get a detailed account of the early childhood history. Parents and older siblings, if alive, can often provide much additional information regarding the past personal history. Not all questions need to be asked from all patients and personal history (much like rest of the history taking) should be individualised for each patient.

Personal history can be recorded under the following headings:

Perinatal History

Difficulties in pregnancy (particularly in the first three months of gestation) such as any febrile illness, medications, drugs and/or alcohol use; abdominal trauma, any physical or psychiatric illness should be asked. Other relevant questions may include whether the patient was a wanted or unwanted child, date of birth, whether delivery was normal, any instrumentation needed, where born (hospital or home), any perinatal complications (cyanosis, convulsions, jaundice), APGAR score (if available), birth cry (immediate or delayed), any birth defects, and any prematurity.

Childhood History

Whether the patient was brought up by mother or someone else, breastfeeding, weaning and any history suggestive of maternal deprivation should be asked. The age of passing each important developmental milestone should be noted. The age and ease of toilet training should be asked.

The occurrence of neurotic traits should be noted. These include stuttering, stammering, tics, enuresis, encopresis, night terrors, thumb sucking, nail biting, head banging, body rocking, morbid fears or phobias, somnambulism, temper tantrums, and food fads.

Educational History

The age of beginning and finishing formal education, academic achievements and relationships with peers and teachers, should be asked.

Any school phobia, non-attendance, truancy, any learning difficulties and reasons for termination of studies (if occurs prematurely) should be noted.

Play History

The questions to be asked include, what games were played at what stage, with whom and where. Relationships with peers, particularly the opposite sex, should be recorded. The evaluation of play history is obviously more important in the younger patients.

Puberty

The age at menarche, and reaction to menarche (in females), the age at appearance of secondary sexual characteristics (in both females and males), nocturnal emissions (in males), masturbation and any anxiety related to changes in puberty should be asked.

Menstrual and Obstetric History

The regularity and duration of menses, the length of each cycle, any abnormalities, the last menstrual period, the number of children born, and termination of pregnancy (if any) should be asked for.

Occupational History

The age at starting work; jobs held in chronological order; reasons for changes; job satisfactions; ambitions; relationships with authorities, peers and subordinates; present income; and whether the job is appropriate to the educational and family background, should be asked.

Sexual and Marital History

Sexual information, how acquired and of what kind; masturbation (fantasy and activity); sex play, if any; adolescent sexual activity; premarital and extramarital sexual relationships, if any; sexual practices (normal and abnormal); and any gender identity disorder, are the areas to be enquired about.

The duration of marriage(s) and/or relationship(s); time known the partner before marriage; marriage arranged by parents with or without consent, or by self-choice with or without parental consent; number of marriages, divorces or separations; role in

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marriage; interpersonal and sexual relations; contraceptive measures used; sexual satisfaction; mode and frequency of sexual intercourse; and psychosexual dysfunction (if any) should be asked.

Conventionally, the details of the 'family of procreation' are recorded here.

Premorbid Personality (PMP)

It is important to elicit details regarding the personality of the individual (*temperament*, if the age is less than 16 years). Instead of using labels such as schizoid or histrionic, it is more useful to describe the personality in some detail.

The following subheadings are often used for the description of premorbid personality.

1. Interpersonal relationship: Interpersonal relationships with family members, friends, and work colleagues; introverted/extroverted; ease of making and maintaining social relationships.
2. Use of leisure time: Hobbies; interests; intellectual activities; critical faculty; energetic/sedentary.
3. Predominant mood: Optimistic/pessimistic; stable/prone to anxiety; cheerful/despondent; reaction to stressful life events.
4. Attitude to self and others: Self-confidence level; self-criticism; self-consciousness; self-centred/thoughtful of others; self-appraisal of abilities, achievements and failures.
5. Attitude to work and responsibility: Decision making; acceptance of responsibility; flexibility; perseverance; foresight.
6. Religious beliefs and moral attitudes: Religious beliefs; tolerance of others' standards and beliefs; conscience; altruism.
7. Fantasy life: Sexual and nonsexual fantasies; daydreaming-frequency and content; recurrent or favourite daydreams; dreams.
8. Habits: Food fads; alcohol; tobacco; drugs; sleep.

One of the most reliable methods of assessment of premorbid personality is interviewing an informant familiar with the patient prior to the onset of illness.

ALCOHOL AND SUBSTANCE HISTORY

Although alcohol and drug history is often elicited as a part of personal history, it is often customary to record it separately. Alcohol and drugs can often contribute to causation of several psychiatric symptoms and are often present co-morbidly alongside many psychiatric diagnoses.

PHYSICAL EXAMINATION

A detailed general physical examination (GPE) and systemic examination is a must in every patient. Physical disease, which is aetiologically important (for causing psychiatric symptomatology), or accidentally co-existent, or secondarily caused by the psychiatric condition or treatment, is often present and can be detected by a good physical examination.

MENTAL STATUS EXAMINATION (MSE)*

Mental status examination is a standardised format in which the clinician records the psychiatric signs and symptoms present at the time of the interview.

MSE should describe all areas of mental functioning (Table 2.2). Some areas, however, may deserve more emphasis according to the clinical impressions that may arise from the history; for example, mood and affect in depression, and cognitive functions in delirium and dementia.

General Appearance and Behaviour

A rich deal of information can be elicited from examination of the general appearance and behaviour. While examining, it is important to remember patient's sociocultural background and personality.

*The definitions of some MSE terms are described in Appendix III.

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Table 2.2: Mental Status Examination

1. **General Appearance and Behaviour**
   - i. General Appearance
   - ii. Attitude towards Examiner
   - iii. Comprehension
   - iv. Gait and Posture
   - v. Motor Activity
   - vi. Social Manner
   - vii. Rapport
2. **Speech**
   - i. Rate and Quantity
   - ii. Volume and Tone
   - iii. Flow and Rhythm
3. **Mood and Affect**
4. **Thought**
   - i. Stream and Form
   - ii. Content
5. **Perception**
6. **Cognition (Higher Mental Functions)**
   - i. Consciousness
   - ii. Orientation
   - iii. Attention
   - iv. Concentration
   - v. Memory
   - vi. Intelligence
   - vii. Abstract thinking
7. **Insight**
8. **Judgement**

Understandably, general appearance and behaviour needs to be given more emphasis in the examination of an uncooperative patient.

General appearance

The important points to be noted are:
Physique and body habitus (build) and physical appearance (approximate height, weight, and appearance),
Looks comfortable/uncomfortable,
Physical health,
Grooming, Hygiene, Self-care,
Dressing (adequate, appropriate, any peculiarities),
Facies (non-verbal expression of mood),
Effeminate/masculine

Attitude towards examiner

Cooperation/guardedness/evasiveness/hostility/combativeness/haughtiness,
Attentiveness,
Appears interested/disinterested/apathetic,
Any ingratiating behaviour,
Perplexity

Comprehension

Intact/impaired (partially/fully)

Gait and posture

Normal or abnormal (way of sitting, standing, walking, lying)

Motor activity

Increased/decreased,
Excitement/stupor,
Abnormal involuntary movements (AIMs) such as tics, tremors, akathisia,
Restlessness/ill at ease,
Catatonic signs (mannerisms, stereotypies, posturing, waxy flexibility, negativism, ambitendency, automatic obedience, stupor, echopraxia, psychological pillow, forced grasping) (see Chapter 5 for details),
Conversion and dissociative signs (pseudoseizures, possession states),
Social withdrawal, Autism,
Compulsive acts, rituals or habits (for example, nail biting),
Reaction time

Social manner and non-verbal behaviour

Increased, decreased, or inappropriate behaviour
Eye contact (gaze aversion, staring vacantly, staring at the examiner, hesitant eye contact, or normal eye contact).

Rapport

Whether a working and empathic relationship can be established with the patient, should be mentioned.

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Hallucinatory Behaviour

Smiling or crying without reason, Muttering or talking to self (non-social speech).

Odd gesturing in response to auditory or visual hallucinations.

Speech

Speech can be examined under the following headings:

Rate and quantity of speech

Whether speech is present or absent (mutism),
If present, whether it is spontaneous, whether productivity is increased or decreased,
Rate is rapid or slow (its appropriateness), Pressure of speech or poverty of speech.

Volume and tone of speech

Increased/decreased (its appropriateness),
Low/high/normal pitch

Flow and rhythm of speech

Smooth/hesitant, Blocking (sudden),
Dysprosody, Stuttering/Stammering/Cluttering, Any accent,
Circumstantiality, Tangentiality,
Verbigeration, Stereotypies (verbal),
Flight of ideas, Clang associations.

Mood and Affect

Mood is the pervasive feeling tone which is sustained (lasts for some length of time) and colours the total experience of the person. *Affect*, on the other hand, is the outward objective expression of the immediate, cross-sectional experience of emotion at a given time.

The assessment of *mood* includes testing the quality of mood, which is assessed subjectively ('how do you feel') and objectively (by examination). The other components are stability of mood (over a period of time), reactivity of mood (variation in mood with stimuli), and persistence of mood (length of time the mood lasts).

The *affect* is similarly described under quality of affect, range of affect (of emotional changes displayed over time), depth or intensity of affect (normal, increased or blunted) and appropriateness of affect (in relation to thought and surrounding environment).

Mood is described as general warmth, euphoria, elation, exaltation and/or ecstasy (seen in severe mania) in mania; anxious and restless in anxiety and depression; sad, irritable, angry and/or despaired in depression; and shallow, blunted, indifferent, restricted, inappropriate and/or labile in schizophrenia.

Anhedonia may occur in both schizophrenia and depression.

Thought

Normal thinking is a goal directed flow of ideas, symbols and associations initiated by a problem or a task, characterised by rational connections between successive ideas or thoughts, and leading towards a reality oriented conclusion. Therefore, thought process that is not goal-directed, or not logical, or does not lead to a realistic solution to the problem at hand, is not considered normal.

Traditionally, in the clinical examination, thought is assessed (by the content of speech) under the four headings of stream, form, content and possession of thought. However, since there is widespread disagreement regarding this subdivision, 'thought' is discussed here under the following two headings of 'stream and form', and 'content'.

Stream and form of thought

For obvious reasons, the 'stream of thought' overlaps with examination of 'speech'. Spontaneity, productivity, flight of ideas, prolixity, poverty of content of speech, and thought block should be mentioned here.

The 'continuity' of thought is assessed; Whether the thought processes are relevant to the questions asked; Any loosening of associations, tangentiality, circumstantiality, illogical thinking, perseveration, or verbigeration is noted.

Content of thought

Any preoccupations;
Obsessions (recurrent, irrational, intrusive, egodystonic, ego-alien ideas);

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Contents of phobias (irrational fears);
Delusions (false, unshakable beliefs) or Over-valued ideas;
Explore for delusions/ideas of persecution, reference, grandeur, love, jealousy (infidelity), guilt, nihilism, poverty, somatic (hypochondriacal) symptoms, hopelessness, helplessness, worthlessness, and suicidal ideation.
Delusions of control, thought insertion, thought withdrawal, and thought broadcasting are Schneiderian first rank symptoms (SFRS). The presence of neologisms should be recorded here.

Perception

Perception is the process of being aware of a sensory experience and being able to recognize it by comparing it with previous experiences.

Perception is assessed under the following headings:

Hallucinations

The presence of hallucinations should be noted. A hallucination is a perception experienced in the absence of an external stimulus. The hallucinations can be in the auditory, visual, olfactory, gustatory or tactile domains.

Auditory hallucinations are commonest types of hallucinations in non-organic psychiatric disorders. It is really important to clarify whether they are elementary (only sounds are heard) or complex (voices heard).

The hallucination is experienced much like a true perception and it seems to come from an external objective space (for example, from outside the ears in the case of an auditory hallucination). If the hallucination does not either appear to be a true perception or comes from a subjective internal space (for example, inside the person's own head in the case of auditory hallucination), then it is called as a *pseudohallucination*.

It should be further enquired what was heard, how many voices were heard, in which part of the day, male or female voices, how interpreted and whether these are second person or third person hallucinations (i.e. whether the voices were addressing the patient or were discussing him in third person); also enquire about command (imperative) hallucinations (which give commands to the person).

Enquire whether the hallucinations occurred during wakefulness, or were they hypnagogic (occurring while going to sleep) and/or hypnopompic (occurring while getting up from sleep) hallucinations.

Illusions and misinterpretations

Whether visual, auditory, or in other sensory fields; whether occur in clear consciousness or not; whether any steps taken to check the reality of distorted perceptions.

Depersonalisation/derealisation

Depersonalisation and derealisation are abnormalities in the perception of a person's reality and are often described as 'as-if' phenomena.

Somatic passivity phenomenon

Somatic passivity is the presence of strange sensations described by the patient as being imposed on the body by 'some external agency', with the patient being a passive recipient. It is one of the Schneider's first rank symptoms.

Others

Autoscopy, abnormal vestibular sensations, sense of presence should be noted here.

Cognition (Neuropsychiatric) Assessment

Assessment of the cognitive or higher mental functions is an important part of the MSE. A significant disturbance of cognitive functions commonly points to the presence of an organic psychiatric disorder. It is usual to use Folstein's mini mental state examination (MMSE) for a systematic clinical examination of higher mental functions.

Consciousness

The intensity of stimulation needed to arouse the patient should be indicated to demonstrate the level of

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alertness, for example, by calling patient's name in a normal voice, calling in a loud voice, light touch on the arm, vigorous shaking of the arm, or painful stimulus.

Grade the level of consciousness: conscious/ confusion/somnolence/clouding/delirium/stupor/coma. Any disturbance in the level of consciousness should ideally be rated on Glasgow Coma Scale, where a numeric value is given to the best response in each of the three categories (eye opening, verbal, motor).

Orientation

Whether the patient is well oriented to time (test by asking the time, date, day, month, year, season, and the time spent in hospital), place (test by asking the present location, building, city, and country) and person (test by asking his own name, and whether he can identify people around him and their role in that setting). Disorientation in time usually precedes disorientation in place and person.

Attention

Is the attention easily aroused and sustained; Ask the patient to repeat digits forwards and backwards (digit span test; digit forward and backward test), one at a time (for example, patient may be able to repeat 5 digits forward and 3 digits backwards). Start with two digit numbers increasing gradually up to eight digit numbers or till failure occurs on three consecutive occasions.

Concentration

Can the patient concentrate; Is he easily distractible; Ask to subtract serial sevens from hundred (100-7 test), or serial threes from fifty (50-3 test), or to count backwards from 20, or enumerate the names of the months (or days of the week) in the reverse order.

Note down the answers and the time taken to perform the tests.

Memory

a. Immediate Retention and Recall (IR and R)

Use the digit span test to assess the immediate memory; digit forwards and digit backwards subtests (also used for testing attention; are described under attention).

b. Recent Memory

Ask how did the patient come to the room/hospital; what he ate for dinner the day before or for breakfast the same morning. Give an address to be memorised and ask it to be recalled 15 minutes later or at the end of the interview.

c. Remote Memory

Ask for the date and place of marriage, name and birthdays of children, any other relevant questions from the person's past. Note any amnesia (anterograde/ retrograde), or confabulation, if present.

Intelligence

Intelligence is the ability to think logically, act rationally, and deal effectively with environment.

Ask questions about general information, keeping in mind the patient's educational and social background, his experiences and interests, for example, ask about the current and the past prime ministers and presidents of India, the capital of India, and the name of the various states.

Test for reading and writing; Use simple tests of calculation.

Abstract thinking

Abstract thinking is characterised by the ability to:

a. assume a mental set voluntarily,
b. shift voluntarily from one aspect of a situation to another,
c. keep in mind simultaneously the various aspects of a situation,
d. grasp the essentials of a 'whole' (for example, situation or concept), and
e. to break a 'whole' into its parts.

Abstract thinking testing assesses patient's concept formation. The methods used are:

a. Proverb Testing: The meaning of simple proverbs (usually three) should be asked.
b. Similarities (and also the differences) between familiar objects should be asked, such as: table/ chair; banana/orange; dog/lion; eye/ear.

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The answers may be overly concrete or abstract. The appropriateness of answers is judged. Concretisation of responses or inappropriate answers may occur in schizophrenia.

Insight

Insight is the degree of awareness and understanding that the patient has regarding his illness.

Ask the patient's attitude towards his present state; whether there is an illness or not; if yes, which kind of illness (physical, psychiatric or both); is any treatment needed; is there hope for recovery; what is the cause of illness. Depending on the patient's responses, insight can be graded on a six-point scale (Table 2.3).

Judgement

Judgement is the ability to assess a situation correctly and act appropriately within that situation. Both social and test judgement are assessed.

i. Social judgement is observed during the hospital stay and during the interview session. It includes an evaluation of 'personal judgement'.
ii. Test judgement is assessed by asking the patient what he would do in certain test situations, such as 'a house on fire', or 'a man lying on the road', or 'a sealed, stamped, addressed envelope lying on a street'.

Judgement is rated as Good/Intact/Normal or Poor/Impaired/Abnormal.

INVESTIGATIONS

After a detailed history and examination, investigations (laboratory tests, diagnostic standardised interviews, family interviews, and/or psychological tests) are carried out based on the diagnostic and aetiological possibilities. Some of these investigations are described briefly in Table 2.4.

FORMULATION

After a comprehensive psychiatric assessment, a diagnostic formulation summarises the detailed posi-

Table 2.3: Clinical Rating of Insight

Insight is rated on a 6-point scale from one to six.
1. Complete denial of illness.
2. Slight awareness of being sick and needing help, but denying it at the same time.
3. Awareness of being sick, but it is attributed to external or physical factors.
4. Awareness of being sick, due to something unknown in self.
5. Intellectual Insight: Awareness of being ill and that the symptoms/failures in social adjustment are due to own particular irrational feelings/thoughts; yet does not apply this knowledge to the current/future experiences.
6. True Emotional Insight: It is different from intellectual insight in that the awareness leads to significant basic changes in the future behaviour.

Table 2.4: Some Investigations in Psychiatry

I. Biological Investigations
Medical Screen
Some of the following tests may be useful in screening for the medical disorders causing the psychiatric symptoms. Some examples of indications are stated in front of the tests (these examples are not intended to be comprehensive).
Haemoglobin: Routine screen.
Total and differential leucocyte counts: Routine screen, Treatment with antipsychotics (e.g. clozapine), lithium, carbamazepine.
Mean Corpuscular Volume (MCV): Alcohol dependence (increased).
Urinalysis: Routine screen; Drug screening.
Peripheral smear: Anaemia.
Renal function tests: Treatment with lithium.
Liver function tests: Treatment with carbamazepine, valproate, benzodiazepines. Alcohol dependence.
Serum electrolytes: Dehydration, SIADH, Treatment with carbamazepine, antipsychotics, lithium.
Blood glucose: Routine screen (age > 35 years), treatment with antipsychotics

Contd...

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Contd...

Thyroid function tests: Refractory depression, rapid cycling mood disorder. Treatment with lithium, carbamazepine.
Electrocardiogram (ECG): Age > 35 years, Treatment with lithium, antidepressants, ECT, antipsychotics.
HIV testing: Intravenous drug users, suggestive sexual history, AIDS dementia.
VDRL: Suggestive sexual history.
Chest X-ray: Age > 35 years, Treatment with ECT.
Skull X-ray: History of head Injury.
Serum CK: Neuroleptic malignant syndrome (markedly increased levels).

Toxicology Screen

Useful when substance use is suspected; for example, alcohol, cocaine, opiates, cannabis, phencyclidine, benzodiazepines, barbiturates; remember that certain medications can cause false positive results (for example, quetiapine for methadone).

Drug Levels

Drug levels are indicated to test for therapeutic blood levels, for toxic blood levels, and for testing drug compliance. Examples are lithium (0.6-1.0 meq/L), carbamazepine (4-12 mg/ml), valproate (50-100 mg/ml), haloperidol (8-18 ng/ml), tricyclic antidepressants (nortriptyline 50-150 ng/ml; imipramine 200-250 ng/ml), benzodiazepines, barbiturates and clozapine (350-500 μg/L).

Electrophysiological Tests

EEG (Electroencephalogram): Seizures, dementia, pseudoseizures vs. seizures, episodic abnormal behaviour.
BEAM (Brain electrical activity mapping): Provides topographic imaging of EEG data.
Video-Telemetry EEG: Pseudoseizures vs. seizures.
Evoked potentials (e.g. p300): Research tool.
Polysomnography/Sleep studies: Sleep disorders, seizures (occurring in sleep). The various components in sleep studies include EEG, ECG, EOG, EMG, airflow measurement, penile tumescence, oxygen saturation, body temperature, GSR (Galvanic skin response), and body movement.
Holter ECG: Panic disorder.

Brain Imaging Tests (Cranial)

Computed Tomography (CT) Scan: Dementia, delirium, seizures, first episode psychosis.
Magnetic Resonance Imaging (MRI) Scan: Dementia. Higher resolution than CT scan.
Positron Emission Tomography (PET) Scan: Research tool for study of brain function and physiology.
Single Photon Emission Computed Tomography (SPECT) Scan: Research tool.
Magnetic Resonance (MR) Angiography: Research tool
Magnetic Resonance Spectroscopy (MRS): Research tool

Neuroendocrine Tests

Dexamethasone Suppression Test (DST): Research tool in depression (response to antidepressants or ECT). If plasma cortisol is > 5 mg/100 ml following administration of dexamethasone (1 mg, given at 11 PM the night before and plasma cortisol taken at 4 PM and 11 PM the next day), it indicates non-suppression.
TRH Stimulation Test: Lithium-induced hypothyroidism, refractory depression. If the serum TSH is > 35 mIU/ml (following 500 mg of TRH given IV), the test is positive.
Serum Prolactin Levels: Seizures vs. pseudoseizures, galactorrhoea with antipsychotics.
Serum 17-hydroxycorticosteroid: Organic mood (depression) disorder.
Serum Melatonin Levels: Seasonal mood disorders.

Biochemical Tests

5-HIAA: Research tool (depression, suicidal and/or aggressive behaviour).
MHPG: Research tool (depression).
Platelet MAO: Research tool (depression).
Catecholamine levels: Organic anxiety disorder (e.g. pheochromocytoma).

Genetic Tests

Cytogenetic work-up is useful in some cases of mental retardation.

Sexual Disorder Investigations

Papaverine test: Male erectile disorder (intracavernosal injection of papaverine is sometimes used to differentiate organic from non-organic male erectile disorder).
Nocturnal penile tumescence: Male erectile disorder.

Contd...

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Contd...

Serum testosterone: Sexual desire disorders, Male erectile disorder.
Penile Doppler: Male erectile disorder.

Miscellaneous Tests
Lactate provocation test: Panic disorders (In about 70% of patients with panic disorders, sodium lactate infusion can provoke a panic attack).
Drug assisted interview (Amytal interview): Useful in catatonia, unexplained mutism, and dissociative stupor. Discussed in Chapter 18.
CSF examination: Meningitis.

II. Psychological Investigations
Objective Tests
These are pen-and-paper objective tests, which are employed to test the various aspects of personality and intelligence in a person.
Objective personality tests: Some examples of objective personality tests are *MMPI (Minnesota multiple personality inventory)* and *16-PF (16 personality factors)*.
Intelligence tests: Some commonly used tests of intelligence are *WAIS (Wechsler adult intelligence scale)*, *Stanford-Binet test* and *Bhatia's battery of intelligence tests*.

Projective Tests
In projective tests, ambiguous stimuli are used which are not clear to the person immediately. Some commonly used projective tests of personality are *Rorschach inkblot test*, *TAT (Thematic apperception test)*, *DAPT (Draw-a-person test)*, and *sentence completion test* (SCT).

Neuropsychological Tests
Some of the commonly used neuropsychological tests are *Wisconsin card sorting test*, *Wechsler memory scale*, *PGI memory scale*, *BG test (Bender Gestalt test)*, *BVRT (Benton visual retention test)*, *Luria-Nabraska neuropsychological test battery*, *Halstead-Reitan neuropsychological test battery*, and *PGI battery of brain dysfunction*.

Rating Scales
Several rating scales are used in psychiatry to quantify the psychopathology observed. Some of the commonly used scales are *BPRS (Brief psychiatric rating scale)*, *SANS (Scale for assessment of negative symptoms)*, *SAPS (Scale for assessment of positive symptoms)*, *HARS (Hamilton's anxiety rating scale)*, *HDRS (Hamilton's depression rating scale)*, and *Y-BOCS (Yale-Brown obsessive-compulsive scale)*.

Diagnostic Standardized Interviews
The use of these instruments makes the diagnostic assessment more standardized. These include *PSE (Present state examination)*, *SCAN (Schedules for clinical assessment in neuropsychiatry)*, *SCID (Structured clinical interview for DSM-IV)*, and *IPDE (International personality disorder examination)*.

tive (and important negative) information regarding the patient under the focus of care, before listing differential diagnosis, prognostic factors, and a management plan.

The diagnostic formulation focuses on aetiological factors based on the biopsychosocial model (Table 2.5; Fig. 2.3). Similarly, it is useful to devise the management plan based on the biopsychosocial model (Table 2.6). It is possible to use specific formulations based on treatment options; for example, a cognitive formulation for CBT and a psychodynamic formulation for psychodynamic psychotherapy.

Thus, psychiatric assessment is an initial step towards diagnosis and management of psychiatric disorders.

Table 2.5: Diagnostic Formulation

	Biological	*Psychological*	*Social*
Predisposing			
Precipitating			
Perpetuating			
Protective			

Table 2.6: Management Plan

	Biological	*Psychological*	*Social*
Short-term			
Medium-term			
Long-term			

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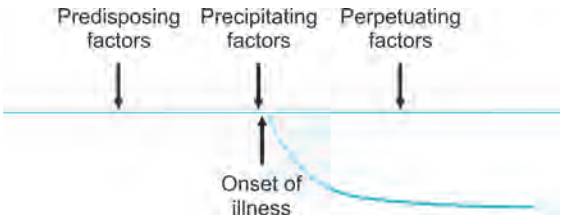


Fig. 2.3: Aetiological Factors Drawn on a Timeline

SPECIAL INTERVIEWS

There are different formats available for detailed evaluation of special populations such as uncooperative patients, hostile and aggressive patients (Chapter 19), suicidal patients (Chapter 19), and children. These formats should be used whenever appropriate.

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A Short Textbook of PSYCHIATRY

Over the last two decades *A Short Textbook of Psychiatry* has enjoyed a wide distribution among the undergraduate medical students, interns, junior residents, postgraduate psychiatry students, nursing students, psychology and psychiatric social work students, occupational therapy and physiotherapy students, general medical practitioners, other physicians and health professionals in India and some other countries. Its original aim of providing a brief yet comprehensive account of psychiatric disorders and their treatment in an easy-to-follow manner has been the guiding principle throughout the last 20 years.

The Seventh Edition of *A Short Textbook of Psychiatry* has been extensively revised and updated with significant changes made in almost all the chapters, particularly in chapters on diagnosis and classification, psychoactive substance use disorders, psychopharmacology, schizophrenia, mood disorders and other biological methods of treatment. User-friendly coloured-shaded boxes have been added at various places in the text to highlight the important points in tables and figures. The chapter on psychiatric history and examination contains a summary of laboratory tests in psychiatry, in addition to other significant changes. The appendices have been revised and contain a glossary of commonly used psychiatric terms which appear throughout this book.

Several readers have provided a very constructive and useful feedback which is very warmly welcome. Please send your constructive comments by email to STBPsy@gmail.com

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