EVALUATION: PSYCHIATRIC HISTORY

PRELIMINARY INFORMATION

Identifying Information

Identification of the case should include the patient's:

- Age
- Marital status
- Race
- Sex
- Religion
- Educational level
- Occupation
- Place of residence
- Date of admission

Referral Source

Name of the referring physician and/or any other source of referral

Sources of Information

Sources of information should include:

- identity of the informants (including the patient)
- an estimate of each informant's reliability
- how many times and how long each informant is interviewed
- letters or phone calls from other physicians

Hospital Justification

Specify why this patient needed to be hospitalized at this time. Usually, a common sense evaluation of the patient's problems will be adequate. Among the numerous reasons for a patient's hospitalization are:

- Lack of appropriate facilities in the patient's hometown
- Need to be removed from stressful life circumstances
- Round-the-clock supervision for adequate evaluation and treatment
- Special diagnostic and treatment procedures which can be most adequately provided in the hospital
- Symptoms too severe for outpatient treatment
- Court-mandated admission
- Failure to respond to outpatient treatment

Chief Complaint

The statement of the problem (chief complaint) consists of a brief description of the nature, duration, and severity of the principal difficulties which necessitated admission of the patient to the hospital. (Use direct quotes from the patient.) Describe the events in chronological sequence, specifying exact dates wherever possible.

PRESENT ILLNESS

Record Events Chronologically

Beginning with the first clear evidence of emotional difficulties or physical symptoms, record the chronology of the present illness up to the date of admission. Note the **exact** sequence of events and record the **exact** dates of their occurrence (or as nearly exact as your informants can give them).

Example: Instead of saying "approximately 2 months prior to admission The patient began to have 'nervous spells', "state: "On May 10, 1962, the Patient had the first of a series of 'nervous spells'."

Use Specific Behavioral Terms

Do not accept vague and general terms which patients and their families frequently use to describe symptoms, and do not be content with the patient's description of his episodes as "nervous spells". Get him to describe the subjective experience of that spell and the accompanying behavioral or observable physical manifestations. In short, get a good behavioral description.

Example: The patient describes his "nervous spells" as episodes in which his heart suddenly begins to beat very rapidly while he feels apprehensive, tremulous, and at times, sweats to the point that he has to mop his brow. If he is writing or eating, his hand may become so tremulous that he is unable to continue or is unable to light a cigarette without his tremor being apparent to onlookers. Although he has never lost consciousness, he almost always has the fear during an episode that he's going to "black out" and fall helplessly unconscious.

Get Context of Symptoms

Attempt to get a complete description of the context in which episodic symptoms occur or the life circumstances leading up to the onset of the more continuous and progressive symptoms. Be especially attentive to preceding life events that have produced change necessitating a significant degree of readjustment, particularly life change events involving loss.

INTERACTION WITH EXTERNAL AGENTS

Substance Use

Inquire tactfully about substances (alcohol, drugs, etc.) that the patient is using or has used extensively. List them and note how long the patient has used them. Get details of amount and frequency of use.

Toxic Exposure

If the patient thinks he may have been exposed to a toxic substance, if he is in an environment (at work, at school, at home, etc.) where he may have been exposed, if he is in an environment (at work, at school, at home, etc.) where he may have been exposed, or if he is simply having unusual health problems, additional inquiry about possible toxic exposure is warranted. Note the toxic substances to which the patient may have been exposed or, if – as is so often the case – they are unknown, the **circumstances** in which he may nave been exposed.

Current Medications

A paragraph should be devoted to the current medications that the patient is using. List those that the patient is taking and note for how long the patient has been on each specific medication.

Past Medications

Inquire about medications that have been used in the past and what effect (good or bad) the medications have had.

Allergies

Record information about any significant allergies, treatment received (if any), and whether or not the treatment was successful.

PAST HISTORY

Medical

Discuss all relevant details of any significant illnesses, injuries, accidents, or operations. Exact dates should always be given. In addition, inquiry should be made as to whether the patient has ever had a blood transfusion.

Special attention should be given to whether or not the patient has ever suffered:

- any kind of head trauma
- episodes of unconsciousness
- convulsive seizures
- episodes of amnesia
- episodes of confusion
- episodes of disorientation

FAMILY HISTORY

Medical and Psychiatric Data

Summarize the medical data regarding physical diseases that have a familial or hereditary tendency and the psychiatric diseases known to have occurred in parents, grandparents, siblings, aunts, and uncles. Specific mention should be made of the presence or absence of the following medical conditions in those family members:

- Cancer
- Allergies
- Diabetes
- Hypertension
- Heart disease

Determine whether these family members have ever suffered from any emotional difficulties or "nervous breakdowns". Where such emotional difficulties have occurred, specify the:

- Nature of the symptoms involved
- Type of treatment provided
- Length of hospitalization (if any)
- Frequency of recurrence

Describe the Patient's Family

In addition to these medical and psychiatric data, the family history should include some reference to: cultural tradition, socioeconomic background, family interest, aspirations, myths, legends, and so forth, that characterize the patient's family of origin. (These aspects of the family history can usually be incorporated in the member-by-member description of the family.) Include a clear statement of the patient's description of each family member, as well as some clear indication of who was important to whom within the family. Note particularly who was important to the patient and how close to one another the various members of the family were in the past and are at the present. Usually, each parent can be described adequately in a paragraph. Some information about the family background of each parent should be given, to give some notion of the circumstances and the type of family in which each parent was reared.

Describe the Patient's Siblings

Describe the parents and the siblings in separate paragraphs. List the siblings in the order of age, including the patient, so that his rank among the siblings is clearly indicated. Include any stillbirths or abortions in their proper chronologic order. A bare minimum of facts about the siblings would include age, education, significant illnesses, occupation, degree of success occupationally and academically, marital status, age at marriage, number of children, and the patient's impression of the marriage of the siblings. In addition to basic facts, explore and record the patient's assessment of each family member's personality and his own relationship to that person.

Illustration (Family History)

Note that here, as elsewhere, direct quotations from the patient are useful.

The family history is negative for cancer, allergies, hypertension, heart disease, or any other serious physical disorders. The patient has one sister who was hospitalized for 3 months in a psychiatric hospital for a state of depression from which she recovered with drug therapy and psychotherapy. He has a younger brother who is an overt homosexual and has been in psychotherapy as an outpatient for several years.

(Father)

Father, age 75, came to this country from England at the age of 7. He began to support himself as a clerk in a store at the age of 14 when both parents died of pneumonia. He has lived in Dallas since coming to this country, and despite having only a high school education, he has acquired a large department store in Dallas and is a very successful businessman. After losing all his money in the Depression of the

(Father - Cont.)

1930's, he built up another business from virtually nothing and was able to retire last year, adequately provided for. The patient describes his father as a "self-made courageous man", but one whose mind is "limited to business things". Now on excellent terms with his father, when younger the patient was intolerant of the father's faults and his tendency to "act the big shot". The father is active in the Methodist Church and makes large annual financial contributions to it. In adolescence and young adulthood, the patient was ashamed of his father's "limited mind", and he rarely introduced his friends to his parents, who were not present at his marriage to his present wife.

(Mother)

Mother, age 68, came to this country from England when she was an infant. She is "thoroughly a Texan" and devoutly Methodist. Although she has only a high school education, she is bright and well read; she is highly respected in Dallas, where she is active in civic activities, particularly civic music affairs. The patient describes her as "loveable, unselfseeking, kind, sensible, and willing to help everyone". He emphasizes her intelligence and her ability to speak with great spontaneity to people from various socioeconomic levels. He's always been very attached to his mother, although he has seen little of her since he was 14 years old, when he left home to go to a prep school.

(Siblings)

Siblings:

1) Sally, age 48, lives in Mount Vernon, N.Y., where she works hard to forward the career of her husband, a judge. In 1950, she had a nervous breakdown, evidently a depression, for which she was hospitalized for 3 months. The patient states that Sally has "made a good adjustment to a disappointing life", meaning that she has been distressed at having no children and a husband who is more attentive to his legal career than he is to her.

2) Florence, age 44, was always the most attractive and socially popular of all of the children. She was the favorite of both parents. She studied drama and was on the stage for a short time, but quit to help her father in his second business venture. Her husband, whom she had married at the age of 28, allegedly attempted to swindle the patient's father in an effort to set up his own business. The patient has been unable to forgive Florence for her effort to defend her husband during that unpleasant episode. He and Florence's husband do not speak to each other. He was not close to Sally or Florence either in childhood or later.

3) The patient, Arnold, age 41.

4) Leonard, age 38, is the only survivor of triplets; the others died at birth or shortly thereafter. Since early infancy, he has been "the weakling of the family" and is described as "undistinguished and not very intelligent". He did not finish high school. An overt homosexual, he has been under psychiatric treatment from time to time without noticeable effect. At present, he is working as an attendant in a state mental hospital in New York. The patient always tended to belittle and bully Leonard in childhood, but since adolescence has had very little to do with him at all.

(Spouse and Children)

Marital Family

Wife, Mary, age 31, is the only and very pampered child of a prominent "old-line" Catholic New Orleans family. Except for her inability to become pregnant again after having had one child, the wife's health has been excellent. She and the patient met at a Mardi Gras party 10 years ago, shortly after she graduated from college. Both the patient and his wife agree that they eloped impulsively and married after only a month's acquaintance. Both families opposed the marriage because of religious differences. The patient describes his wife as a "spoiled child who constantly demands attention". Their relationship has deteriorated steadily for the past 2 or 3 years but especially so in the last 3 months.

Son, Arnold Jr., age 8, is a bright, active, healthy child. Very close to his father, the boy has little to do with his mother, who allowed a longtime family maid to rear him almost entirely.

PERSONAL HISTORY

Milestones

Record chronologically the developmental milestones of the patient as a person, beginning with the date and place of birth and ending with the onset of the present illness.

Childhood History

Include the date and place of birth and describe the family circumstances (social, economic, emotional) at the time of the pregnancy and birth, including the parents' health and marital relationship. Was the pregnancy desired? Was the birth full term and normal? What was the patient's birth weight? Was the patient breast or bottle fed? Did he feed normally and gain weight? Was he healthy? Note the ages at: walking, talking, weaning, and toilet training. Note early infections and whether these seemed to influence the development of the child. Obtain information concerning the formation of habits with special reference to bed-wetting, night terrors, sleepwalking, fingernail biting, thumb-sucking and stuttering. Take note of any history of stomach and bowel complaints, headaches, or other special invalidism and psychosomatic disorders. Patients rarely remember events before the third or fourth year and often relate what they have learned from parents; the source of information should be indicated. An informative question is, What is the first thing in your life that you remember?' The answer, even though it may represent a "screen memory", may be very informative. Other early memories may be sought.

Next, inquire into the preschool years (approximately age 3 to 6) with regard to whatever can be determined about family circumstances and physical, emotional and social development as well as physical health. How did he get along with his siblings, with other children his own age, and with older and younger children? The sleeping relations of early childhood may be of interest. One should have a clearly detailed story of the first six years of life, including those special, significant events which might have influenced the course of development.

Adolescent History

Obtain a chronological account of major events during the primary or grammar school years and the junior high, high school and college years. By breaking the early history into these segments one can often help the patient and other informants to remember specific events that might be overlooked.

Obtain information about personal problems that were experienced during puberty and adolescence, especially in terms of social relationships in school, in play, hero worship, interpersonal relationships, tendency to associate with the same or opposite sex, religious and sexual attitudes, evidence of philosophical ruminations, obsessive thinking, compulsions or phobias. Judgment must be used when requesting sexual information. Various opportunities will arise though the information should then be organized and recorded in a section labeled, "Sexual History". The following topics are fruitful areas for tactfully exploring sexual development in the course of taking the history:

- Relationship with parents
- Birth of siblings
- Menstrual history
- Pregnancies
- Attitude toward sexual issues
- Problems of the patient's children

Marital History

However, if the patient is married, it is logical to begin with the marriage and courtship, and then work back. Obtain information, if available, concerning:

- Development of interest in sexual topics
- Type and richness of sexual fantasies
- Sex instruction received in childhood

Marital History – (Cont.)

- Attitudes of the parents and family toward these subjects
- Evidence of any perversions or untoward experiences
- Attitude of the patient toward marriage and the responsibilities of family life

Note any sexual incompatibilities with the spouse; premarital and/or extramarital sex; and attitude toward birth control, especially as a cause of conflict. Obtain information about:

- Masturbation – age, frequency, feelings about it, reactions and statements of others
- Childhood sexual experiences, age at puberty, relationships with the opposite sex, dates, parties, dances, frequency of dating, feelings of ease or discomfort, crushes
- First heterosexual experiences
- Homosexual experiences
- Engagement; length of courtship with spouse; parental attitudes toward the marriage

Educational History

Give in detail the age at which school was started and finished. Evaluate:

- The school record
- The social adaptation
- The patient's general attitude toward schooling and intellectual pursuits

Vocational History/Economic Status

The vocational history should detail, chronologically, the jobs held, wages earned, and reasons for changes. From this, one should gather a clear account of:

- Ability in the competitive field
- The possibilities of good interpersonal relationships
- The ability to give and take orders
- The amount of ambition and energy

Describe the patient's reaction to promotion, demotion, and responsibility. Note periods of economic stress and, if applicable, the reaction to unemployment or welfare status.

Military History

Military data should include:

- Branch of service
- Duration and dates
- Experience
- Combat
- Injury
- Illness
- Rank on entry and at discharge, type of discharge, i.e., honorable, medical, etc.
- Effect of military service on the patient's life situation both at induction and at discharge
- Problems arising after discharge
- Hospitalizations

Legal History

Note details of any problems involving the law:

- Arrests, jail or prison time
- Charges or convictions
- Lawsuits

Also, record the patient's attitudes toward these events.

Religious History

Gain insight into the patient's religious beliefs and practices and any associated satisfactions and/or conflicts.

Leisure and Social History

How does the patient spend leisure time? Sports, hobbies, clubs, social organizations? What does he read or watch on TV? Does he have friends and associates, and what is their relationship? Some awareness of the patient's cultural and social aspirations, interests and frustrations is important. A picture of the cultural and social setting in which the patient lives should be obtained.

Adult Life History

Issues important in the mid-phase of adulthood should be discussed when applicable:

- Parenthood
- Grandparenthood
- Death of parents
- Work
- Health and marriage

Issues important in late adulthood are:

- Retirement
- Financial security
- Death of the spouse
- health problems

Current Living Status

With whom does the patient live? Spouse, children, parents, friends, significant other, relatives other than immediate family, landlord, renter? Does he live in a house or an apartment? What is the neighborhood like? Does he own or rent his habitation? Is he responsible for maintaining it? Has there been any recent change in any of these factors?

Remember!

- Chronology is of great importance and it is advisable, wherever possible, to record significant events by designating the year they occurred and the age of the patient at the time of the occurrence.
- The patient's feelings about events in his life and relationships with people are as important as the actual facts regarding those events and relationships.

Reorganize And Retrace

Much of the information will be obtained during history-taking in a haphazard order. Once the material is obtained, it should be reorganized and recorded in a more systematic form. At that time, areas of omission or areas where important information is missing will be discovered. These omissions may reflect anxiety-provoking topics which the patient consciously or unconsciously avoids and should be retraced and picked up in an additional interview.

REVIEW OF SYSTEMS

Ask whether the patient has ever had each symptom of each system. **Record only positive findings.**

SYSTEM	SYMPTOMS
General	weight change, weakness, fatigue, fever, chills, heat intolerance, sleep disturbance
Skin	rashes, itching, changes in skin texture or hair
Eyes	changes in vision, glasses, diplopia, blurred vision, scotoma, eye pain photophobia
Ears	hearing loss, tinnitus, vertigo, ear pain, ear discharge
Nose	epistaxis, nasal discharge, obstruction, sinusitis
Throat and Mouth	teeth, denture, abnormal taste, sore mouth or tongue, gums, sore throats, speech difficulty, hoarseness
Neck	areas of swelling, pain, goiter, masses or nodes
Cardio-respiratory	cough, dyspnea, wheezing, hemoptysis, chest pain, palpitations, orthopnea, paroxysmal nocturnal dyspnea, edema, high blood pressure, syncope
Gastro-Intestinal	anorexia, nausea, vomiting, hematemesis, melena, dysphagia, heartburn, flatulence, abdominal pain, jaundice, change in bowel habits, diarrhea, constipation, hematochezia, rectal pain
Reproductive System-Female	age at menarche, menstrual cycle, last menstrual period, gravida, para abortus, age at menopause, dysmenorrhea, menorrhagia, metrorrhagia, dyspareunia, method of contraception, pelvic pain, sexual dysfunction, ability to achieve orgasm, discharge, venereal disease, breast mass, breast pain, breast discharge
Male	sexual dysfunction, discharge, venereal disease
Urinary System	dysuria, frequency, nocturia, hematuria, urgency, incontinence, polyuria
Musculo-Skeletal	backache, joint pain, stiffness
Hematologic	bleeding tendencies, bruising, anemia
Neurological	headache, head injuries, seizures, syncope, impaired memory, impaired coordination, impaired or disturbed sensation

*****

EVALUATION: MENTAL STATUS EXAMINATION

INTRODUCTIION

Methodology

The physician gathers mental status data from a patient by two modes:

- Relatively objective examination procedures
- Personal judgment of the patient's traits and status

Pitfalls

Many students are understandably reluctant to make subjective evaluations for fear of passing unsound or unfair judgment. The physician must:

- Avoid being moralistically judgmental
- Understand and respect the beliefs, customs, and attitudes of people with various backgrounds

Yet he must learn to observe carefully and, on the basis of those observations, make informed judgments on the behavior and emotional state of a patient. Unfortunately, there are no definitive procedures for doing this.

Obvious Examples

The way a patient dresses can be an important clue to emotional health. If dress is grossly inappropriate or bizarre, it can signal a psychosis.

Examples:

- A 65-year-old woman with a paunchy abdomen and flabby, obese legs comes into a clinic or office in a brief and revealing miniskirt.
- A medical school applicant comes to the admissions committee interviews barefoot and wearing military medals.

Difficult Cases

How should one decide what is appropriate dress (or behavior, etc.) in less obvious cases, when meeting a patient for the first time? Remember that physicians are constantly making decisions and judgments about the physical and emotional health of their patients, sometimes crucial ones based on minimal data.

Essential Skills

There are two essential skills in making timely and accurate decisions for patient care. The physician must:

- Become an acute observer of people and their behavior
- Learn to record observations accurately

Learning to observe and to record data about patients' mental health are skills that must be developed, just like hearing and describing cardiac murmurs.

Categories

The data from a mental status examination are recorded and organized into six categories:

- General appearance, behavior and speech
- Mood and affect
- Intellectual functions
- Evaluation of thought processes
- Insight
- Judgment and reliability

This chapter will elaborate on each of these categories.

GENERAL APPEARANCE AND BEHAVIOR

Observation

The physician should gather data about the patient's appearance and behavior throughout the interview. This requires constant, sharp, and accurate observation.

Criteria

The following are indicators to be scrutinized:

- Handshake
- Expression
- Gait
- Posture
- Attitude toward examiner
- Eyes – movement and contact
- Dress – hair, makeup, clothing

The patient's speech is particularly important. Is it:

- Too slow, blocked, halting, or stuttering?
- Too fast, rhyming, or punning?

Is the patient's speech laden with:

- Stereotypes?
- Other oddities?

Example

Below is an excerpt from a mental status examination that records the patient's appearance and behavior accurately:

The patient is a tall, slender young man who appears and acts more like he is 15 years old than his actual age of 19. He walks in an awkward, gangling manner and seems to be all arms and legs. His handshake was limp and his hands were cold and sweaty. He sat slumped in his chair with his head and eyes downcast most of the time. He rarely moved about in his chair during the interview and gave the impression that he was ready to run form the office at any moment. He was dressed casually, in frayed and dirty blue jeans, a tattered, dirty sweatshirt, and frayed tennis shoes. His face appeared tense, and he rarely looked at the examiner. When he did, his eyes seemed apprehensive, and he acted as if he expected to be scolded or severely reprimanded at any moment. His hair was shoulder length but carefully and neatly combed. He spoke in low, sullen tones and rarely gave more than the briefest answers to most questions. Toward the latter part of the interview, he became obviously more relaxed and less tense, and he began to talk in a much more spontaneous manner. At no time did he smile or make any show of friendliness toward the examiner.

Review

Once again, the physician is the examining instrument for this part of the interview and must make accurate observations in order to judge a patient's emotional state correctly.

MOOD AND AFFECT

Description

Patient's mood (prevailing emotional tone) and affect (transient shifts in emotions) should be described in terms of: a) **type**; b) **intensity and variability**; and c) **appropriateness**.

Type of Affect

- Verbal – Patients may reveal their affective state verbally, stating that they feel sad, angry, suspicious, etc.
- Non-Verbal – Patients may express their affective state non-verbally, manifesting it in behavior, expression, or general demeanor.

Questioning the Patient about Affect

If the patient appears in a particular affective state but makes no mention of it, the physician should comment on this appearance, using confrontation to determine if that is how the patient feels. This procedure should be done whenever the patient is obviously expressing an affect non-verbally.

Categories of Affect

The following categories of affective states are commonly recognized:

- normal
- elated, euphoric
- depressed
- guilty
- anxious
- hostile
- suspicious
- flat

Intensity and Variability

Look for these differences in affect:

- Intensity – Is the patient severely or only slightly affected?
- Variability – Does one affect persist (i.e., unwavering indifference – a "flat" affect)? At the other extreme, does the patient's affect fluctuate rapidly and extremely? Either extreme is an ominous sign of severe emotional disturbance.

Appropriateness

The patient's affect should be judged as appropriate or inappropriate in reference to the:

- topic or content about which the patient speaks
- reality of the patient's current circumstances

The following chart gives examples of both kinds of affect:

	APPROPRIATE	INAPPROPRIATE
Topic of Conversation	• Depressed patient talks mostly. about sad or distressing events. • Elated patient talks mainly of exciting and pleasant events. • Anxious patient expresses fearful thoughts. • Suspicious patient talks of ominous plots.	• Certain patients, usually schizophrenics, may express bizarre and frightening delusions (e.g., that rays from the TV are causing their brains to rot) while laughing and giggling. • Severely disturbed patients, exhibit a flat affect, that is, unwavering indifference to sad, happy, or frightening events.
Reality of Circumstance	• Depressed and bereaved patient who has lost a loved one expresses sadness. • An attorney in a locked psychiatric ward under court commitment worries about the consequences for his future work.	• A bereaved person expresses no sadness or depression. • A physician committed to a closed psychiatric unit expresses extreme confidence that the world will eventually honor his genius.

INTELLECTUAL FUNCTIONS: OVERVIEW

Introduction

This part of the examination involves systematic and relatively objective testing of the patient's intellectual abilities. Intellectual function testing does not depend as much on the physician's subjective impressions and judgment as most other parts to the mental status examination.

Primary Significance

The data from this part of the examination are of special significance for differentiating disturbances caused by organic brain disease from the functional psychiatric disorders:

- neuroses
- psychoses
- personality disorders
- transient situational stress reactions with no known organic cause

Secondary Significance

Also detected are particular patterns of thought which differentiate the psychoses:

- schizophrenia – fragmented and concrete
- depression – slowed or retarded
- mania – rapid and distractible

Functions to Be Evaluated

The examination consists of evaluations of the patient's:

- sensorium
- memory
- problem-solving ability
- capacity for abstract thought
- fund of general knowledge
- basic intelligence level

Techniques for evaluating each function are discussed on the following pages:

INTELLECTUAL FUNCTIONS: SENSORIUM

Definition

Sensorium refers to the patient's orientations to:

- Person: Does he know who he is?
- Place: Does he know where he is?
- Time: Does he know the day of the month and the year?

Determining Orientation to Person and Place

The physician can usually determine whether the patient is correctly oriented to person and place without asking directly. Close observation should reveal the patient's orientation during the interview.

Determining Orientation to Time

The physician will usually have to ask the patient about his orientation to time. Tactful comments and questions should elicit adequate responses.

Example: "Now I want to ask you some questions to see how well your memory works. For example, can you tell me what the date is today? (If the patient simply replies "Yes," don't believe it).
"What is the date?" (If the patient says "The tenth of the month," ask "The tenth of what month?" and if needed, "Of what year?"

INTELLECTUAL FUNCTIONS: MEMORY

Memory Testing

Memory is tested by giving the patient a few simple tasks to perform. The goal is to determine if either of these types of memory has been impaired:

- **RECENT** – the last few minutes, hours, days
- **REMOTE** – the last few months, years, or longer

and thus to begin to differentiate between organic brain disease and functional mental disease.

Types of Memory Impairment

- In organic brain disease, recent memory is usually impaired, but remote memory remains intact unless the disease is severe.
- In functional mental disease, memory is usually intact. However, anxious, depressed, or confused patients may have great difficulty cooperating in a memory test.

Test Technique

Tell patients that to determine how well their memory works, you want to give them some simple tasks.

Recent Memory: Test Address

STEP	PROCEDURE
1	Tell patients you will give them a street address to remember, and you will ask for it in about five minutes. • Say: "The address is 713 Osborne St." • Repeat it to be sure the patient understands. • The number should contain three digits, and the street name should not be common. • Use the same address with all patients.
2	Proceed with other aspects of memory testing.
3	After about 5 minutes, ask patients to recall the address. Patients of normal intelligence can recall correctly the address unless they have organic brain disease.

Recent Memory: Digit Recall

In this part of the examination, the patient is asked to repeat a series of random numbers, first forward, then backward. In testing the patient's memory for digits, it is best to use a written list of random numbers like the ones below:

Be prepared: Do not try to make up the number list during a test; confusion will result.

FORWARD	**BACKWARD**
5 - 8 – 2	2 – 4
6 – 9 – 4	5 – 8
6 – 4 – 3 – 9	6 – 2 – 9
7 – 2 – 8 – 6	4 – 1 – 5
4 – 2 – 7 – 2 – 1	3 – 2 – 7 – 9
7 – 5 – 8 – 3 – 6	4 – 9 – 6 – 8
6 – 1 – 9 – 4 – 7 – 3	1 – 5 – 2 – 8 – 6
3 – 9 – 2 – 4 – 8 – 7	6 – 1 – 8 – 4 – 3
5 – 9 – 1 – 7 – 4 – 2 – 8	5 – 3 – 9 – 4 – 1 – 8

Procedure

Follow the procedure given below:

- Tell the patient:
  "I am going to read a series of numbers to you. When I have read them, I want you to repeat them to me. For example, I will say 1 – 2 – 3."
- Continue with 3 digits, then 4, up to 7, noticing how many the patient can repeat before making mistakes.
- Give the patient the same instruction, but tell him to repeat the numbers backward.

Normal Memory

Patients with normal intelligence can usually repeat six (6) digits forward and five (5) in reverse. Patients who are known to have had normal intelligence in the past and who can repeat no more than 5 digits forward, 4 in reverse usually have an organic brain disease.

Recent Memory: Recall of Events

Questions in this category further test the patient's recent memory, and help determine the level of intelligence.

Definition

Confabulation is the tendency of patients with impaired memory due to organic brain disease to fill in the blank spots in their impaired memory by unconsciously (that is, without deliberate intent) making up answers for questions to which they cannot remember the proper answer. Patients with organic brain disease confabulate in order to avoid the painful realization that their memory is impaired.

Test Technique

Ask the patient about the following topics:

- What was for breakfast?
- How long have you been in the hospital?
- What has been on TV lately?
- What have you read in newspapers, books, or magazines?

Be able to check the patient's answers (particularly for the first two questions) for any confabulations.

Remote Memory

Remote memory is very rarely impaired in any psychiatric disorder. It begins to show impairment only in severe organic brain disease.

Test Technique

One can test remote memory by asking about the following vital statistics (and others like them):

- Date and place of birth
- Date and place of high school or college graduation
- Date of marriage

The accuracy of answers to these questions must be verifiable.

Remote memory, as well as intelligence, can also be tested by asking the patient about major historical events in a field in which he indicates a personal interest (history, sport, TV, etc.).

- What happened to J.F. Kennedy?
- When was WW II?
- Who was Winston Churchill?
- In what sport was Joe Louis famous?
- What (in sport) was Murderers' Row?
- What sport is played at the Rose Bowl?
- What was Sputnik?
- What is the Berlin Wall?
- What was Watergate?
- Where is Vietnam?

INTELLECTUAL FUNCTIONS: PROBLEM SOLVING

Introduction

To evaluate a patient's problem-solving ability, the physician must consider:

- the patient's degree of cooperation
- whether the patient is anxious, preoccupied, or distractible
- the patient's basic intelligence and education level
- the patient's socioeconomic background

Examples

- The college graduate who cannot perform simple arithmetic problems and is obviously trying to cooperate very likely suffers from organic brain disease.
- A similar inability in a patient from a deprived socioeconomic background and with no education may not indicate organic brain disease.
- An anxious, distracted, or uncooperative patient may not perform well, but organic brain disease would not be indicated.

Comment

Most patients with functional psychiatric illness are not impaired in their fundamental abilities of remembering accurately or solving problems. But anxiety, depression, distraction, or preoccupation will prevent patients from performing well, fully, or even attempting the tests. However, patients with organic brain disease may be fully cooperative but unable to solve all but the simplest problems.

The Tests

The tests used to evaluate problem-solving ability are:

- simple multiplication
- more complex arithmetic, including word problems
- subtraction of serial sevens

Instructions

In testing the ability of a patient to perform complex intellectual tasks, the physician must start with the simplest problems, then progress to more complex ones. In this way the point at which the patient begins to fail can be determined accurately. Consequently, the degree of impairment can be estimated. If the patient is initially given a task beyond his ability, anxiety may result in poor performance on even simple tasks.

Simple Multiplication

Have the patient perform the following multiplications without paper and pencil:

5 x 3	5 x 15
5 x 5	5 x 19
5 x 10	5 x 23
5 x 13	5 x 52

Word Problems

These problems involve more than one task. The patient must understand and remember the problem as it is read, then do the calculation. Thus recent memory is also tested.

Examples:

- If you travel 300 miles in your automobile going 50 miles per hour, how long does it take to complete the trip?
- If you travel 3,000 miles in your automobile at 50 miles an hour, how long does it take to complete the trip?
- If you travel 300 miles in your automobile at 50 miles an hour, but stop twice, once for one hour for lunch and once for three hours for dinner, how long does it take you to reach your destination?

Word Problems (Cont.)

- If you buy six apples at 13 cents each but get home and find two of the apples are bad and return these two and get your money back on them, how much did you spend for the apples that you kept?

Subtraction of Serial 7's

Instruct the patient to subtract 7 from 100, then 7 from the difference, and so on, until nothing is left. Demonstrate the process if necessary.

Purpose of Test

This examination tests the patient's problem-solving ability as well as recent memory and concentration.

Number of Mistakes

A person of normal intelligence should make no more than two mistakes. Four mistakes or more in a person who formerly had normal intellectual abilities suggest organic brain disease, although poor performance may reflect symptoms of functional mental disorders.

Patterns of Mistakes

The examiner should record the patient's answers as they are given, because the pattern of mistakes also provides helpful diagnostic information:

- An anxious or less intelligent person may make mistakes but will probably note lose his place in the calculations.
- A patient with severe organic brain disease will forget the order.
- A typical serial 7 pattern in organic brain disease is as follows: 100, 93, 86, 96, 89, 91, 84, 74, 64, 54, etc.

INTELLECTUAL FUNCTIONS: CAPACITY FOR ABSTRACT THOUGHT

Introduction

Capacity for abstract thought is determined by testing the patient's:
a) **ability to interpret proverbs**; b) **ability to compare physical objects**; and c) **spontaneous expression of concrete thought**.

Proverb Interpretation

This ability is tested by giving the patient a series of proverbs and asking what they mean. An adult of average intelligence is usually capable of abstract thinking. **Abstract thought** implies in this test the explanation of a proverb in conceptual or figurative terms, rather than in just concrete or literal terms.

If an adult patient has average intelligence, but is unable to give adequate abstractions of the following proverbs (even one or two of them), **schizophrenia should be strongly suspected unless there is gross evidence of organic brain disease.**

Impairment

The indications of impairment are as follows:

UNIMPAIRED	PARITIALLY IMPAIRED	FULLY IMPAIRED
Normal patient	• Organic brain diseases • Mental defectives • Severe manias • Deprived backgrounds	Schizophrenics

Delivery

Each proverb should be prefaced by the comment, "Now tell me what this saying means." If a patient is unfamiliar with the proverbs, he should still have no trouble explaining their meanings.

"Don't count your chickens before they are hatched."
Concrete answer – It is not a good idea because some of eggs may not be fertilized.

Delivery – (Cont.)

Adequate abstraction – It means don't always think things will turn out like you hope they will.
Superior abstraction – Hopeful anticipations may not become reality.

"Don't cry over spilled milk."
Concrete answer – Once milk is spilled there is no way to get it back into the bottle or use it.
Adequate abstraction – It does no good to worry about things that happened in the past.
Superior abstraction – Past misfortunes can't be changed by regrets.

"The squeaky wheel gets the grease."
Concrete answer – The wheel that squeaks needs grease more than a wheel that doesn't squeak.
Adequate abstraction – The person who complains loudest gets the most attention.
Superior abstraction – Vigorous protest calls attention to problems that need correction.

"Don't change horses in mid-stream."
Concrete answer – It is a bad idea because you might fall off and get wet or drown.
Adequate abstraction – It is better to carry through with a project than to keep changing from one to another.
Superior abstraction – Indecision prevents progress.

"People who live in glass houses shouldn't throw stones."
Concrete answer – They would break their house if they threw stones.
Adequate abstraction – You should not criticize others if you have weaknesses and faults yourself.
Superior abstraction – Imperfections produce vulnerability.

"You catch more flies with honey than with vinegar."
Concrete answer – Flies like sweet things and swarm to them and can be caught. They don't like vinegar.
Adequate abstraction – If you have a sweet disposition, you will have more friends than if you are a grouch.
Superior abstraction – Kindness is a more powerful influence than criticism.

Similarities

In this part of the examination the patient is told: Now I will name for you two objects such as an apple and an orange, and I will ask you to tell me in what way the two objects are similar."

To be sure that the patient understands the task, first explain that an orange and apple can be said to be similar in the following ways:

- Both have skins.
- Both are colored.
- Both have seeds.
- Both can be eaten.
- Both are fruit.

Do not give the patient any clues as to which kind of answer is preferable.

Use of the Test

The use of similarities to detect abstract thought has advantages over the use of proverbs, in that the test is less dependent on educational level or socio-economic background, and it is easier to explain to unsophisticated patients.

Interpretation

If one asks a patient about the similarities between a dog and a cat and the patient states that both are mammals, he has demonstrated a good capacity for abstract thought – both belong to a general class or category. But if the similarities are "Both have fur" or "Both are pets", he is not thinking in abstract terms and can grasp only partial or concrete shared attributes.

Procedure

After making sure the patient understands the task, read the pairs given below, and **record** the answers. Preface each pair with the question, "How are the following similar?"

- Table and desk.
  Abstract answer – Both are furniture.
  Concrete answer – Both are made of wood (or have four legs, etc.).

- Coat and sweater.
  Abstract answer – Both are clothes.
  Concrete answer – You wear them (or they are usually made of wool, etc.).

- Cup and pitcher.
  Abstract answer – Both are eating utensils.
  Concrete answer – You can put milk or water in both of them.

- Wine and whiskey.
  Abstract answer – Both are alcoholic beverages.
  Concrete answer – Both make you drunk (or both are sold in bottles).

Spontaneously Expressed Concrete Thought

The presence of concrete thought and inability to abstract may also be detected in spontaneous comments. For example, when a patient was asked "What brought you to the hospital?" (meaning what symptom), he replied, "An automobile brought me." When the patient was asked, "What kind of building are you in now? (meaning type of institution), he said it was a building made of bricks.

INTELLECTUAL FUNCTIONS: FUND OF GENERAL KNOWLEDGE

Introduction

The questions below test: a) **remote memory**; b) **level of intelligence**; c) **breadth of knowledge**.

The questions are most applicable to middle-class patients of normal intelligence. Other questions must be devised to test patients of different backgrounds or intelligence.

Example: A migrant farm worker may be quite informed about seasonal changes and related work in different parts of the country but be unable to respond to the questions below.

Sample Questions

- Name three major world rivers.
- Name the capitals of four large countries.
- Who is our president? Who was the president before him?
- Who is the vice president?
- Who is the governor?
- What is the state capital?
- When did World War II start?
- What Is NASA?

INTELLECTUAL FUNCTIONS: GENERAL ESTIMATE OF INTELLIGENCE

Estimating Intelligence

The physician can make a remarkably accurate estimate of the patient's general level of intelligence form the patient's: a) **performance on mental status tests**; b) **vocabulary**; and c) **occupational history**. Use your own personal experience and judgment to gauge the patient's intelligence.

Categories of Intelligence Levels

Taking into account the above three criteria, estimate the patient's intelligence in terms of:

- above average intelligence (on par with most people you knew in college)
- average intelligence (capable of high school but probably not of college work)
- below average intelligence (probably not capable of high-school-level tasks)

EVALUATION OF THOUGHT PROCESSES: TYPES OF THOUGHT PATTERNS

General Comments

The pattern of a patient's thought processes can be judged from the style in which the patient expresses himself. In recording the mental status examination, one should describe the pattern of thought the patient exhibits. This part of the examination is of **special significance for detecting schizophrenic thought disorders**.

Clear, Coherent Thought

If the patient thinks in a clear and coherent pattern that is easy to follow and understand, one can be reasonably certain that he does not suffer from a major psychotic disturbance.

Circumstantial Thought

This type of thought is manifested in a style of speaking that includes many tedious and irrelevant details before the real point of the idea is expressed. Circumstantial thought suggests that the patient is suffering from one of the following:

- organic brain disease
- obsessional personality traits
- schizophrenia

Circumstantial Thought in Organic Brain Disease

Many elderly people whose faculties are beginning to decline are extremely long-winded and take a long time to reach the point of a story. When this occurs in patients who are not senile but show other evidence of organic brain disease, it can help to confirm a diagnosis.

Circumstantial Thought in Obsessive Patients

There are people who, for the sake of completeness and attention to detail, find it hard to omit any possible idea or fact that might be cogent to the point they are trying to express. Whether or not this type of circumstantially reflects an obsessive-compulsive tendency must be determined form other findings of the history and mental status examinations.

Circumstantial Thought in Schizophrenia

An extreme degree of circumstantiality is suggestive of schizophrenia; it borders on the confused, fragmented thought symptomatic of this illness.

Formal Thought Disorders

There is no generally accepted definition of formal thought disorder. In this manual, the term is used to describe several readily identifiable but not mutually exclusive disturbances of speech or thinking. In certain contexts, they strongly suggest schizophrenia. However, they should not be counted as evidence of formal thought disorder in the following situations:

Formal Thought Disorders – (Cont.)

- transcient overwhelming affect (such as fear or anger)
- sarcasm or humor
- limited intelligence or education
- language or cultural differences

Neologisms and Blocking

Neologisms and blocking are not included as phenomena of formal thought disorders because of:

- general unreliability of clinical judgment of them
- the unlikelihood that either would be the **only** manifestation of a formal thought disorder

Documentation

Always document a purported finding with an example from the patient's speech. Five thought disorders follow, with examples of each.

Incoherence

Incoherence occurs when understandability of speech is impaired by distorted grammar, incomplete sentences, lack of logical connection, or sudden irrelevancies.

Example:

"I don't quite gather. I know one right and one left use of both hands, but I can't follow the system that's working. The idea is meant in a kind way, but that's not the way I understand life…."

Loose Associations

Loose associations involve repeatedly juxtaposing things which lack a readily understandable relationship or shifting idiosyncratically from one frame of reference to another.

Examples:

- "I'm tired. All people have eyes…."
- In response to a question about his concern that he will be deserted by his friends, a patient replies, "I wonder what's for dessert today?"

This latter example is frequently referred to as a clang association, in which the connection is based on the sound of words rather than their meaning.

Illogical Thinking

Illogical thinking occurs when facts are obscured, distorted, or excluded. This is a complex and subtle judgment, which usually requires further exploration of the patient's reasoning.

Example:

- A patient refuses to sit on a chair because it's yellow.
- A patient explains that she gave her family punched IBM cards to overcome communication difficulties with them.
- In answering questions about his first hospitalization, a patient replies, "I could have been a few years before or after I was born."

Poverty of Speech Content

Poverty of speech content occurs when speech conveys very little information because of vagueness, talking past the point, empty repetitions, or the use of obscure or stereotyped phrases. Poverty of content is **not** necessarily poverty of **amount** of speech. Because one may recognize this disorder in one's colleagues, politicians, and others, it should only be noted when it assumes clearly pathological proportions.

Von Domarus's Disorder

Von Domarus's disorder of thought is characterized by considering two things as identical because they share one or two attributes.

Von Domarus's Disorder – (Cont.)

Examples:

- A woman believed she was the Virgin Mary because her name is Mary.
- A man believed he was a woman after he noticed blood on his sheets (women bleed, I bled, therefore…).

Flight of Ideas Characteristic of Manic States

Flight of ideas is characteristic of the elated, hyperactive, and speeded-up manic. The manic talks and thinks rapidly and is easily distracted. Unlike the schizophrenic fragmentation of thought, flight of ideas retains some logical connection between words and phrases. However, the manic jumps rapidly from one topic to another without completing any of them.

Example:

In reply to a doctor's question about his well-being, a patient says, "I'm fine! You look well too! That's a pretty tie you are wearing. My mother makes ties. She is married to a very rich man. Have you ever seen a family where everyone drives a Cadillac? But I like Lincoln Continentals better. What kind of car do you drive, Doctor? By the way, when can I leave the hospital? There's a bus at 9 p.m. Can I take it? Buses are more comfortable than trains, don't you think?..."

Retarded Thought Characteristic of Depressive Reactions

Severely depressed patients speak in a slow, halting fashion. It is an effort for them to speak at all and they are preoccupied with ideas of gloom and hopelessness. They may express delusional ideas of worthlessness and guilt, but these ideas will be expressed in a coherent manner.

EVALUATION OF THOUGHT PROCESSES: UNUSUAL THOUGHTS AND PREOCCUPATIONS

Introduction

In this section of the mental status examination, the physician describes unusual or pathologic beliefs, thoughts, or experiences that the patient may have. These include:

- delusions
- hallucinations
- depersonalization
- obsessions
- compulsive rituals
- phobias

In the course of obtaining the history, there may be some obvious evidence or subtle hints that the patient suffers from one of these unusual modes of thought. Inquire about it tactfully. Try to obtain as clear and specific a description of the experience as possible.

Questions about Anxiety

When patients complain of anxiety, ask, "Are there specific situations or other things that cause you to be anxious – like high buildings, elevators, certain animals, or things like that?"

Questions about Hallucinations

Inquire tactfully about the presence of hallucinations by asking, "Have you had any unusual experiences that bothered you – like the feeling that people were talking about you, or that you were hearing strange sounds?"

Questions about Obsessions

To elicit information regarding obsessional thoughts, one can ask, "At times, do you have thoughts that you don't like to come into your mind – thoughts that you have difficulty getting out of your mind?"

Questions about Compulsions

Regarding compulsive acts, ask, "At times do you feel compelled to do certain things or else the anxiety gets worse – such things as counting to a certain number or knocking on wood or the like?"

Questions about Paranoia

With very suspicious patients, ask, "Have there been times when people have had it in for you, or tried to cause you problems or harm?"

Delusions

These sample questions should be useful for the physician attempting to elicit information about different types of delusions. (Different types of delusions will be discussed in the next few pages).

Thought Broadcasting

This is the belief that thoughts are broadcast out from the head and into the world so that others can hear them. This can be a delusion and/or a hallucination. If it's the latter, the patient hears his own thoughts from the outside, not just within the head.

Example: A man believed that his thoughts were picked up by a hidden microphone and broadcast on TV.

Thought Insertion

Thought insertion is the belief or experience that thoughts which are not one's own are being inserted into one's mind.

Example: A woman believed that thoughts were being put into her mind by radar.

Thought Withdrawal

Thought withdrawal is the belief that thoughts have been removed from the head, so that fewer thoughts remain. This is extremely rare and you must be completely convinced that it is present before recording the phenomenon.

Delusions of Being Controlled or Influenced

The belief or experience that feelings, impulses, thoughts or actions are not one's own and are imposed by some external force. It does **not** include the convictions that:

- the patient is acting as an agent of God
- a curse has been placed on the patient
- the patient is a victim of fate, or is not assertive enough
- someone is attempting to control the patient

The essential characteristic is that the patient is sure that his will, thoughts, or experiences are being replaced by some other force.

Examples:

- A man claimed his words were not his own, but his dad's.
- A student believed her actions were controlled by a yogi.
- A housewife believed that sexual desires were being put into her body.

Other Bizarre Delusions

Bizarre delusions, (other than those already mentioned), suggest schizophrenia, even if they are of short duration. To be bizarre, a delusion must be patently absurd, fantastic or implausible. It does not include delusions which are the elaboration of common implausible ideas or subcultural beliefs such as communicating with God, the devil, ghosts, or ancestors, or being under the influence of curses, spells, voodoo, or hypnosis.

Examples:

- A man believed that, when his adenoids had been removed, a box had been inserted in his head along with wires so that the voice he heard was Governor Nelson Rockefeller's.
- A woman believed that an underground radio station was broadcasting through noise that emanated from her washing machine.

An example of a non-bizarre delusion would be a man believing that because his appearance had changed, people no longer respected him.

Multiple Delusions

Multiple delusions are two separate delusional beliefs which are not elaborations of a single theme.

Example: A woman felt that nurses approached her with homosexual intentions; the patients were really nurses and doctors in disguise planted there to assist her; and people could read her mind by looking at her hands.

A man who believed that some unknown force had enlisted his family, friends, and associates in a scheme to kill him, and that they poisoned his food and tapped his phone did **not** have multiple delusions because a single theme was being elaborated.

Delusions in Schizophrenia or Affective Disorders

Delusions in schizophrenia or affective disorders include:

- **delusions of grandeur** – exaggerated ideas of one's importance, power, or worth.
- **delusions of persecution** – belief that one has been singled out for mistreatment, harassment, or other forms of persecution.
- **delusions of reference** – the belief that casual and objectively unrelated remarks made by other people or acts performed by others are done with some special relevance to the deluded person. These beliefs may have a paranoid or grandiose quality.
- **delusions of guilt** – ideas of worthlessness and guilt, sometimes involving the belief that one is the object of scorn because of misdeeds of one sort or another.

Hallucinations

This term refers to a false sensory perception that occurs in the absence of any external stimulus, as opposed to an illusion, the misinterpretation of an actual sensory experience. The following indications are important:

- **Hallucinations usually indicate a psychotic condition**, and they may involve any sensory modality.
- Auditory hallucinations are most characteristic of schizophrenia.
- Visual or tactile hallucinations are often characteristic of organic brain syndromes; for example, seeing rats, snakes, or pink elephants, and feeling worms crawl on the skin during *delirium tremens*.
- Olfactory hallucinations suggest an organic problem.

Depersonalization

Feelings of unreality or strangeness. The victim may feel that he is unreal, or not really alive, or that the world around is strange and unreal. When such a feeling is persistent, it indicates a serious psychiatric illness, usually schizophrenia.

Obsessional Ideas

Obsessional ideas are persistent ideas or impulses to control some act, ideas that cannot be eliminated from consciousness by logic or an effort of the will, and that are felt as unwanted and intrusive. Common features of obsessions are:

- They are characteristic of an obsessional neurosis and are usually of a distasteful aggressive or sexual nature.
- Most normal people have similar experiences – e.g., an annoying tune that creeps into the consciousness for a few hours.

Compulsive Rituals

The term 'compulsive rituals' refers to repetitive actions that a person feels compelled to carry out against the will. The person usually believes that unless the compulsive ritual is performed catastrophe will happen. Compulsive acts are similar to the fairly common tendencies that relatively normal people have to 'knock on wood' or adhere to other superstitions and rituals. The compulsive

Compulsive Rituals – (Cont.)

patient has no option but to follow the ritual in order to avoid feeling very apprehensive.

Phobias

These are persistent, unrealistic fears of certain objects or situations. The objects often reflect a degree of danger, e.g., dogs, knives, airplanes, or thunderstorms. The patient often realizes the irrationality of the fear but is unable to control it. This symptom is characteristic of the phobic neuroses, although a patient with several incapacitating phobias may be suffering from an incipient schizophrenic breakdown.

JUDGMENT AND RELIABILITY

Judgment

In this section of the mental status examination the physician records an estimate of how good the patient's judgment is.

Examples:

- A manic patient who has recently invested $10,000 in a business venture to construct a diamond-making machine surely has impaired judgment and is at least ill-advised.
- A patient who realizes that he has some emotional difficulty and has sought help for it on his own obviously has good judgment.

Reliability

The physician should also gauge the reliability of a patient as an informant. A patient's reliability is determined in part by comparing the history obtained from him with that obtained from other informants.

Examples:

- Alcoholic patients are notorious for minimizing the extent of their drinking. Talking to a member of the family, one may learn that what the patient said "was just a drink or two" could be a quart of whiskey per day.
- A patient who contradicts himself without seeming to realize it gives independent evidence of unreliability, and one can make a determination of reliability without outside corroboration.

These patients would be considered to be unreliable informants.

INSIGHT

Insight

In this category, the physician records an impression of how much awareness the patient has of his own impairment.

Examples:

- A paranoid patient with the systematized delusional belief that the hospital is run by communists who are attempting to brainwash him and make him a traitor to his country obviously has little or no insight into his own psychosis.
- A patient with a phobia of elevators may say that her fears are irrational and that she wants help for them. She gives sound evidence of insight about her problem.

PROBLEM LIST

Use Behavioral Terms

List the problems in the patient's life and describe them in behavioral terms, rather than in diagnostic or technical terms or in psychiatric jargon.

Categories

The categories of problems given below should always be covered, even if only by a statement that no significant problems exist in a particular category.

CATEGORY — PROBLEMS

Psychiatric

Note the outstanding behavioral and subjective manifestations of the patient's psychiatric difficulties.

Example: If the patient is obviously schizophrenic, this list might be:

- paranoid delusions
- confused thinking
- homicidal impulses
- hostile impulsive behavior
- auditory hallucinations

Medical

List symptoms and signs such as vomiting, diarrhea, headache, fever, etc.

Family

Use descriptive statements such as:

- excessive dependence on spouse
- episodes of temper tantrums in relation to the spouse
- overprotective attitude toward children

Social-Interpersonal

Note the difficulties that the patient has getting along with other people and coping with ordinary social relationships, activities, and obligations.

Example:

- becomes apprehensive in social groups
- becomes irrationally hostile toward authority figures at work
  Give examples.

Occupational

Note the difficulties that stem from:

- work life, with particular reference to difficulties in getting along with colleagues, superiors, or subordinates
- being promoted or demoted: a change to a different job; impending dismissal or retirement
- technological changes in his job that make him outmoded

Educational

For patients who are in some active educational program, note academic difficulty, conflicts with teachers or fellow students, erratic academic performance, or excessive conscientiousness or irresponsibility regarding educational activities, as well as the patient's participation in extracurricular activities. Give examples.

Economic

Include problems due to indebtedness, sudden affluence, etc. How a patient handles money and the pressures that he is under from economic factors in his life are often crucial and should be specified here. Give examples.

Ethnic

This applies primarily to members of minority groups and should contain examples of ethnic difficulties that arise from the patient's attitudes and subjective experiences, as well as from real and actual discrimination or other ethnic problems.

DIAGNOSIS

Assessment

Summarize findings supportive of those disease conditions the patient may be suffering from. Systematically compare and contrast the patient's clinical findings with what is expected for each.

Working Diagnosis

In most cases, an absolutely definite diagnosis will not be possible at this point in the workup. For medical and legal reasons, it is important that this is a **working** diagnosis and not the **final diagnosis**.

Standards for Nomenclature

- All diagnoses of non-psychiatric conditions must be recorded according to the *Standard Nomenclature of Diseases and Operations.*
- All psychiatric diagnoses must be according to the categories and terminology of *Diagnostic and Statistical Manual of Mental Disorders – DSM-IV TR*.