CHAPTER

1

Introduction to Psychiatry

Competencies: PS 1.1–PS 1.3 | **Domain:** Knowledge/Skill

Specific learning objectives: By the end of this chapter a third-year medical student will be able to:

1. Describe the classification of Psychiatric Disorders and its basis.
2. Elicit, present and document a history in patients presenting with a mental disorder
3. Describe the importance of establishing rapport with patients
4. Perform, demonstrate and document a mini mental examination

CLASSIFICATION IN PSYCHIATRY

Classification is the process by which the complexity of phenomena is reduced by arranging them into categories according to some established criteria for one or more purposes. In psychiatry, a critical problem in the development of classification of diseases is the fact that for most mental disorders there are no biological markers that allow identifying or separating them.

Key Terms

Syndrome: A cluster of symptoms that can result from different disease processes. For example, cough and fever can result from bacterial, fungal or viral infections, or autoimmunity, all processes implying different interventions and outcomes.

Disorder: Something of a medical concern in a patient, an abnormality, injury, disability, or aberration. It implies that exact cause or pathophysiology remains unknown. The term "disease" implies a known pathological process.

Diagnosis is simply the opinion that a given disorder is present (or absent) in a patient.

Diagnostic classification is the listing of diagnoses grouped by relatedness (for example, infectious, autoimmune diseases, cancer, or injuries in medicine, or anxiety, affective or psychotic disorders in psychiatry).

Classificatory Systems

a. **International Classification of Diseases:** The International Classification of Diseases (ICD) is a diagnostic system developed by the World Health Organization (WHO) to classify diseases, health conditions, and related health problems.

It was originally designed by Jacques Bertillon in the late 19th century as the Bertillon Classification of Causes of Death, later evolving into the ICD system.

The ICD-10 was published in 1992, with Chapter V (F00–F99) devoted to Mental and Behavioural Disorders.

The ICD-11, released by the WHO in 2022, replaces ICD-10 and reflects advances in neuroscience, genetics, and cross-cultural psychiatry.

Its corresponding section, Chapter 06, is titled "Mental, Behavioural or Neurodevelopmental Disorders."

ICD-11 offers simplified diagnostic guidelines, dimensional symptom descriptions, and greater clinical utility, especially for comorbid presentations.

Aspect	ICD-10 (1992)	ICD-11 (2022)
Chapter	V (F00–F99)	06
Terminology	"Mental and behavioural disorders"	"Mental, behavioural or neurodevelopmental disorders"
Coding system	Alphanumeric (F00–F99)	Numeric with stem codes (e.g. 6A20)
Structure	Category-based (e.g. schizophrenia, mood disorders)	Spectrum-based, dimensional model
Personality disorders	10 categorical types	Single diagnosis with trait qualifiers (e.g. anankastic, dissocial, anxious)
Gender incongruence	Classified under mental disorders	Moved to sexual health chapter
Obsessive–compulsive and related disorders	Grouped with anxiety disorders	Now a separate block (OCD and related)
Neurodevelopmental disorders	Limited to childhood (e.g. autism, ADHD)	Extended across lifespan
Stress-related disorders	PTSD, acute stress reaction	Expanded to include complex PTSD and prolonged grief disorder
Substance use disorders	Based on dependence model	Focus on "disorders due to substance use or addictive behaviours" (includes gambling, gaming)

Overview of ICD-10, Chapter V		
S. No.	***ICD No.***	***Disorders***
1.	F00–F09	Organic, including symptomatic, mental disorders
2.	F10–F19	Mental and behavioural disorders due to psychoactive substance use
3.	F20–F29	Schizophrenia, schizotypal and delusional disorders
4.	F31–F39	Mood (affective) disorders

S. No.	ICD No.	Disorders
5.	F40–F48	Neurotic, stress-related and somatoform disorders
6.	F50–F59	Behavioural syndromes associated with physiological disturbances and physical factors
7.	F60–F69	Disorders of adult personality and behaviour
8.	F70–F79	Mental retardation
9.	F80–F89	Disorders of psychological development
10.	F90–F98	Behavioural and emotional disorders with onset usually occurring in childhood and adolescence

b. **Diagnostic and Statistical Manual of Mental Disorders (DSM)**: American Psychiatric Association publishes DSM. First DSM was published by American Psychiatric Association (APA) in 1952. DSM-IV was published in 1994 and DSM-IV-TR (Text Revision) in 2000. The current DSM-5 was published in 2013. Both ICD and DSM are based on clinical features only.

c. **Other classificatory systems**
   i. Chinese Classification of Mental Disorders (CCMD) is published by the Chinese Society of Psychiatry. Current edition (CCMD-3) is based on both clinical features and etiology.
   ii. Latin American Guide for Psychiatric Diagnosis (GLAPD) is followed in Latin America.
   iii. In Japan, both ICD and DSM are used along with their traditional classificatory system.

d. **Research Domain Criteria (RDoC):** RDoC was launched in 2009 by National Institute of Mental Health (NIMH), US. RDoC is a research framework for investigating mental disorders. It integrates many levels of information (from genomics and circuits to behaviour and self-report to explore basic dimensions of functioning that span the full range of human behaviour from normal to abnormal.

SIGNS AND SYMPTOMS OF COMMON MENTAL DISORDERS

Eyes do not see what the mind does not know. Assessing patient's mental state is an art as well as science. Capacity to collect clinical data and to organize it scientifically requires skill and basic knowledge about symptoms and signs of the mind.

In psychiatry the differentiation between symptoms and signs is blurred and often both are studied and described together as a phenomenon. Therefore, study of symptoms and signs is also referred to as phenomenology. The other term for the same mentioned in books is symptomatology. Preconceived ideas and theories are avoided as far as possible while recording of these symptoms and signs.

We planned to discuss symptomatology of common mental disorders under the following headings for better understanding for students:

1. Disturbance of General Appearance and Behavior

a. **Catatonia:** A psychomotor syndrome characterised by disturbances in movement, posture, and responsiveness.

It may manifest as stupor, negativism, mutism, waxy flexibility, echolalia (repetition of words), echopraxia (imitation of actions), posturing, or episodes of catatonic excitement.

Catatonia can occur in schizophrenia, mood disorders, or general medical conditions.

b. **Self-neglect:** Marked lack of attention to degree of cleanliness, state of hair, grooming, clothing, etc.
c. **Gesture:** Any action that sends a visual signal to the onlooker.
d. **Mannerism:** Odd stylized movement specific to an individual, which sometimes may be suggestive of special meaning or purpose, e.g. saluting, action of unzipping trousers, etc.
e. **Posturing:** Assumption and maintenance of uncomfortable postures for prolonged periods, e.g. twisting his own arm and maintaining that position for hours together. Usually, such postures have symbolic meaning, e.g. standing as if on a crucifix with both arms stretched.
f. **Stereotypy:** Continuous mechanical repetition of speech or movement without any obvious symbolic meaning for the patient, e.g. rocking back and forth.
g. **Perseveration:** Persistent repetition of the same response or words to different stimuli, e.g. Q. What is your name? Ans: Shyam. Q. Where do you live? Ans: Shyam Q. What is your father's name? Ans: Shyam and so forth.
h. **Ambitendence:** When patient performs a series of alternate opposite movement, e.g., repeatedly extending hands for handshake and then withdrawing before the action is completed and then again extending the hand and so on.
i. **Distractibility:** Inability to sustain attention. Usually, patient is distracted due to trivial stimuli.
j. **Restlessness/agitation/nervous tension:** Restlessness refers to inability to sit still even for brief duration of time with constant fiddling and shifting. If it is associated with anxiety then it is known as agitation. Restlessness confined inside the body is referred to as nervous tension. It is unpleasant and not under voluntary control.
k. **Aggression:** It is motor component of rage, anger or hostility. Goal directed. It may be verbal or physical.
l. **Automatic obedience:** Patient carries out every command regardless of the consequence.
m. **Echopraxia:** Patient imitates action which they see.
n. **Echolalia:** Patient repeats what they hear.
o. **Negativism:** Patients do exactly opposite of what they are told to do. They actively resist efforts to persuade them to comply.
p. **Waxy flexibility:** Patient's limb and hands can be placed in any position in which they remain for a long time.
q. **Cataplexy:** Temporary sudden loss of muscle tone.
r. **Stupor:** Marked reduction in motor movements with preserved consciousness. Patient appears to be motionless and responds poorly to stimuli except to those of extreme pain.

Clinical hint: Unkempt and disheveled in cognitive disorder, pinpoint pupils in narcotic addiction, stooped posture in depression, air of confidence and infectious

gaiety in mania, suspiciousness and odd behavior in schizophrenia, lack of concern for the symptoms in conversion disorder, tremulousness in alcohol withdrawal.

2. Disturbance of Emotion

Emotion is one of the important components of psychiatric evaluation. Skill of eliciting affect and mood states can be important in differentiating between primary psychotic versus mood disorders and even organic from functional conditions.

Definitions: Important terms to know:

a. **Feeling:** It is a positive or negative reaction to some experience or event and is the subjective experience of emotion.
b. **Emotion:** Complex feeling state with psychic, behavioural and somatic components.
c. **Mood:** It is a pervasive and sustained emotion that colours the person's perception of the world.
d. **Affect:** It is a short-lived emotion and is assessed by observation of body language and facial expressions.

   It is important to understand the concepts of mood and affect. Mood is subjective experience of individual and longitudinal while affect is objective assessment and cross sectional. Simple analogy used is that of season and weather. Mood is like the season which is the predominant climate over a few months and affect is like the weather which pertains to conditions on that particular day. For example: It is summer season but today it is cloudy. Similarly, mood may be sad over the last one week but cross-sectionally affect may be cheerful.
e. **Expression of affect**
   i. *Depressed*—downturned angles of mouth, dropping shoulders and posture, retardation, omega sign, veraguth fold, tearing of eyes, furrowing of forehead.
   ii. *Euphoric/cheerful*—facial emotion of happiness, being jovial, smiling/laughing
   iii. *Elation*—euphoria with increased psychomotor activity (distractible, picking cues from environment)
   iv. *Exaltation*—Elation with grandiosity
   v. *Ecstasy*—extreme sense of happiness. Person may be catatonic. 'nirvana'
   vi. *Irritable*—narrowing of palpebral fissures, clenching of teeth, associated increase in gestures, rising tone of voice
   vii. *Anxious*—restless fidgeting, worried, furrowing of forehead
   viii. *Fearful*—widened eyes, hyper vigilant, constantly looking back over her shoulder
   ix. *Perplexed*—look of bewilderment or puzzled expression confusion without disorientation. Commonly seen in evolving schizophrenia/acute psychotic states
   x. *Blunt/Flat*—lack of emotional expressions. Commonly seen in chronic schizophrenia.

Clinical hint: Sadness in depression, cheerfulness and boisterousness in mania, incongruous affect in schizophrenia, flat affect in parkinsonism.

3. Disturbance of Thought

Assessment of thought is important in almost all psychiatric conditions. Considering that humans express their thoughts through speech, the assessment of thought relies

on language. The line of divide between thought and speech abnormalities is thin and may be artificial. However, it is important to avoid misdiagnosing neurological condition resulting in speech abnormality as thought disorder. Assessment of thought requires a skilled interview and a good rapport with the subject. We can discuss disturbance of thought under the following headings:

a. **Form of thought:** It is the structure and organization of thinking. It is assessed during the interview process and by recording verbatim the patient's speech sample. The disturbance of flow of thought often described as loosening of association.

   Examples for common formal thought disorder

   i. **Derailment**—one thought slides into another
      - I am going to Bangalore. Ramesh is very smart

   ii. **Omission**—senseless omission of a thought or part of it
      - This person Mr……. told me that …sleep

   iii. **Fusion**—heterogenous elements of thought are interwoven together
      - I am going to very smart

   iv. **Drivelling—**disordered intermixture of constituent parts of one complex thought
      - He shot a bullet. Tiger jumped on him. He went to forest. He shocked.

   v. **Substitution**—major thought is substituted by a subsidiary one
      - Question: Which festival will you celebrate? Answer: We will celebrate…. at my sister's place.

b. **Stream of thought:** It is related to the flow of thought process which is the determining tendency of thinking. This is significantly influenced by the emotional state of the individual.

   a. **Flight of ideas:** When the flow is significantly increased like in mania, there is loss of direction in thinking resulting in irrelevant and incoherent speech. It is usually associated with pressure of speech and distractibility. There can be chance association between the thoughts and is usually related to internal and external cues.

   b. **Prolixity:** When there is increase speech, but the individual reaches goal, then it is called prolixity, which is usually seen in hypomania. In prolixity the person has increased speech output associated with lively embellishment and is able to reach the goal.

   c. **Circumstantiality:** Here the thinking proceeds slowly with many unnecessary trivial details with tedious elaboration but finally the point or goal is reached.

   d. **Retardation of thinking:** Here the train of thought is slow down and the number of ideas and images which present themselves are decreased. It is usually seen in patients with retarded depression.

   e. **Thought block:** It is the sudden arrest of train of thought, leaving a blank and some patients may become acutely aware of the same. It is usually seen in patients with schizophrenia.

   f. **Thought perseveration:** It is the persistence of the mental operations beyond the point of relevance and thus prevent progressive thinking. It can be of three types—compulsive, inability to switch and ideational perseveration. It can be either verbal or ideational. It is usually seen in organic disorders of brain like dementia—frontotemporal dementia and in chronic schizophrenia.

c. **Possession of thought:** Normally, the subject experiences his thinking as being his own although this sense of personal possession is never in the foreground of his consciousness. There is also a feeling of control over his thinking. It can be affected when there is loss of sense of control over this thinking. The disorders of possession of thought includes thought alienation and obsessions.
   a. **Thought alienation:** This phenomenon is present when the individual feels that he has lost control over his thinking and an outside agency is trying to control or participating in his thinking.
   b. **Thought broadcast:** In thought broadcast, the patient knows that as he is thinking everyone else is thinking in unison with him. Patient reports that others are getting to know what he is thinking simultaneously or in unison with him. Sometimes patient experiences that his thoughts are escaping silently and after they escape they may be available to other people—this feeling of thoughts getting diffused from mind is referred to as thought diffusion. Sometimes, a patient hears his own thoughts being spoken aloud, and as a consequence, other people are able to hear his thoughts as well. Though few authors consider this as thought broadcast, traditionally it is classified as thought echo.
   c. **Thought insertion:** It is said to occur when the patient thinks that thoughts are being inserted into his mind against his will and he recognizes it to be foreign and coming from without.
   d. **Thought deprivation/thought withdrawal:** patient finds that as he is thinking his thought suddenly disappear and he is acutely aware of the same.
   e. **Obsession:** Repetitive, intrusive own thoughts, ideas, impulses, images, which is acknowledged as ego-dystonic, absurd or irrational and there is an attempt to resist them and leads to significant anxiety and distress. Dimensions of obsessions based on the content: Contamination, doubts, aggressive, sexual—blasphemous, symmetry and hoarding.
   f. **Compulsion:** These are mental or motor acts by an individual to lessen the distress or anxiety generating out of obsessions. Example: Repeated handwashing by the person having 'contaminant' obsession is a compulsion.

d. **Content:** Evaluation of content of thought is necessary to understand the patients concerns and ideas. Disorders of content relate to the 'what', as opposed to the 'how', of thinking—to the ideas and beliefs one holds. It is also appropriate to record here any abnormal ideas and beliefs the prototypical abnormality being delusions, others include overvalued ideas, obsession and compulsions, depressive ideas about future, self and environment, ideas of reference. All patients attending a psychiatrist should be evaluated for suicidality.
   a. **Delusions:** It is a firm, fixed belief, which is held on inadequate ground and is not amenable to rational argument and persists despite giving evidence to the contrary and is not in consonance with individual's educational, social and cultural background.

      Stages in delusion formation: Five stages as proposed by Conrad:
      i. Trema: Delusional mood representing a total change in the perception of the world.
      ii. Apophany: Search for and finding of new meaning to psychological events.
      iii. Anastrophy: Heightening of the psychosis.

iv. Consolidation/apocalypse: Formation of new world based on new meanings.
v. Residuum: Eventual autistic state.

Characteristics of Delusions

Primary or secondary delusion: Secondary delusions are usually secondary to other morbid phenomenon like disturbed mood state or perceptual abnormalities or personality disorders. Delusions occurring de novo/autochthonous in otherwise healthy individual they are called primary delusions. It could be one of the following three.

i. **Sudden delusional idea:** It occurs as a single stage. Delusion appears fully formed in the mind.
ii. **Delusional atmosphere (delusional mood):** Patient knows that something uncanny is going on around him which concerns him but he cannot tell what it is. When a delusional perception or sudden delusional idea arises it becomes obvious and he accepts that with a feeling of relief.
iii. **Delusional perception:** Attribution of a new meaning usually in the sense of self reference to a normally perceived object.

Content (types) of delusion: Persecutory, referential, jealousy, love/erotomaniac, hypochondriacal, grandiose, guilt, nihilistic delusion or delusions of poverty and delusional mis-identification.

Single or multiple beliefs: If there are multiple beliefs, whether they are logically built or connected, which is called systematization.

Bizarre delusions: Beliefs which are implausible and completely impossible

- Elaboration of the belief with acting out behaviour and disturbed affect.
- Whether the beliefs are congruent to the underlying mood state or not.

b. **Overvalued ideas:** These are beliefs which, because of the excess of emotional tone invested in them, come to dominate to an abnormal degree. They do not have obsessional characteristics (i.e. they are not recognized as absurd or resisted.
but rather are qualitatively akin to 'preoccupations' that any of us can, from time to time, develop. Examples include querulous paranoid states, morbid jealousy and hypochondriasis. Another example of an overvalued idea, which also illustrates Jasper's argument that not all fixed, incorrigible beliefs are delusions, is the core belief of anorexia nervosa.

c. **Suicidal ideas:** While assessing suicidal ideas and behavior, it is necessary to be sensitive and ask appropriate questions to elicit risk of suicidality. Presence of thoughts of helplessness, worthlessness and hopelessness (Beck's triad—depressive cognition) may be the beginning of suicidal behavior.

- Look for death wishes: Individual has the wish to die. Wants a passive death. Example: It will be better if I sleep tonight and do not get up at all tomorrow morning.
- Suicidal ideas: Individual has an active wish to die however have not decided the means. Example: Doctor, nowadays I just feel that it is better for me to kill myself than undergoing this suffering.
- Suicidal plan: Individual has an active wish to die and also has formulated the means to achieve the same. Example: I just do not want to be on this earth anymore. I will drink pesticide in my room tonight and kill myself.

Clinical hint: Depression patients may herald suicidal thoughts, unusual and bizarre beliefs in schizophrenia and delusional disorder, loosening of association in schizophrenia, flight of idea in mania, concrete thought in mentally challenged and dementia.

4. Disturbance of Perception

Definitions

Perception: Perceiving is not merely receiving a sensation. Sensation plus attributing a meaning to it is perception. For eg: Hearing a tick tock is a sensation. Hearing the tick tock sound and knowing that it is coming from a clock which is hung on the wall opposite me is perception.

Disorders of perception

a. **Sensory distortion:** Change in spatial form of perception or change in intensity or quality of the stimulus.
b. **Sensory deception**
   i. **Illusion:** Misinterpretation of stimuli arising from external object
   ii. **Hallucination:** A false perception in the absence of sensory stimulus to the corresponding sense organs. They are classified depending on the type of sensory organs (auditory, visual, olfactory, gustatory and somatic/tactile). We need to differentiate between 3 possible perceptual disturbances: Hallucinations, pseudo hallucinations, imagery.

   Pseudohallucination is an involuntary sensory experience vivid enough to be regarded as a hallucination, but considered by the person as subjective and unreal.

   Imagery: Increased imaginations or mental images, which can be terminated at will.

   Characteristics of hallucinations

   Hallucinations do not occur exclusively in psychiatric patients but are also common in organic brain syndrome (delirium) and epilepsy. Depending upon the content of the hallucination it may be elementary (simple) or complex. Elementary hallucinations are simple noises or imagery like whistles, creaking noise or flashes or light. Complex hallucinations are fully formed voices (auditory hallucination) which could be male or female or they could be in the form of a scene (visual hallucinations). They could belong to familiar or unfamiliar persons. If the voices speak directly to person, they are second person. If the voices talk among themselves then they are third person auditory hallucinations.
c. **Depersonalization:** Feeling that one is not oneself or something has changed in his or her personality.
d. **Derealization:** Feeling that one's environment has changed in some strange way that is difficult to describe.

Clinical interpretations of Hallucinations

i. Presence of specific types of hallucinations such as running commentary, third person auditory hallucinations, thought echo are First rank symptoms with diagnostic significance.

ii. Presence of visual hallucinations should sensitize the clinician to the possible presence of organicity.
iii. Olfactory hallucinations could be part of aura or ictal phenomenon in complex partial seizures.
iv. Hallucinations can occur in individuals with sensory deprivation. This phenomenon is called Charles Bonnet syndrome. Elderly people with paraphrenia and multimodal hallucinations should be evaluated for sensory impairment (cataract, hearing loss).
v. Presence of command hallucinations should sensitize clinician to possible risk of harm to self or others. The hallucination may command individual to attempt suicide or attack perceived persecutor.
vi. Sometimes it may become difficult to differentiate between a hallucination and delusion. Commonly this in the case of gustatory hallucination (person may say family members are persecuting him because he can taste or smell poison in his food). This can also occur in case of delusion of reference (person may say people are talking about him and he knows this because he can hear people talking about him).

HISTORY TAKING

History taking is a clinical interview, the focus of which is to obtain adequate information in order to arrive at a clinical diagnosis. There may be a lot of contextual information related to circumstances, events and psychosocial stressors which may be important to understand the person's reaction and significance of the event but may not be relevant for clinical diagnosis. Hence, the interviewer may need to filter these out. While analysing and organizing the information collected the principle of 'atheoretical' nature of psychiatric diagnosis needs to be kept in mind. The interviewer should be non-judgmental and empathetic in approach to the interview. Certain questions may need to be asked in a specific set manner to elicit correct information and eliminate subjectivity in interview techniques and make the process of eliciting information reproducible.

Sociodemographic details (ask for name, age, gender, socio-economic status and average family annual income, marital status, occupational status)

Informant: Record who is the informant (name and relationship to patient)/reliability of information (Is the information consistent, corroborative, and continuous?)/ Adequacy of information (Is the information adequate to come to a provisional diagnosis?)

Presenting complaints: Present the main 3–4 complaints preferably in patients' words (avoid technical terms and arrange in chronological order).

Onset: The time period between when symptoms started and reached maximum intensity. (Abrupt—within 48 hours, acute—within 2 weeks, insidious—gradual)

Course: Continuous/fluctuating/episodic

Precipitating factor: Record significant events—biological or psychosocial (which may be deemed to be associated as a triggering factor with the onset of illness)

History of presenting illness: Elaborate the presenting complaints in a descriptive manner to elicit all information pertaining to the symptoms. The flow of description

should be such that at the end of history, the listener should be able to make a fair estimation of possible diagnosis. One way is to think of differential diagnosis for your complaints and arrange your information including and excluding possible diagnosis. In psychiatric history it is easy to get carried away by describing only contextual actors and stressors reported by over anxious informants. While they are important, they do not help in diagnosis and decision making. It may be necessary for interviewer to filter information and focus on eliciting symptoms.

Thumb rules to follow

- Elaborate each presenting complaint for onset, duration, progression
- Ask for and cover symptoms in all 3 domains of thought/emotions/behavior
- Describe the socio-occupational dysfunction caused by the symptoms
- A good way to do this is to describe a typical day of the patient and activities over a 24-hour period
- Describe biological functions: Sleep/appetite/sexual activity
- Describe associated stressors
- Check for history of substance use
- Always check for risk of harm to self or others (Suicidal ideation/attempts/aggression)
- Check for potential legal issues
- **Start negative history with:** Symptoms of likely diagnosis which are not present in this patient. Other psychiatric symptoms which are absent to rule out differential diagnosis and neurological and medical symptoms/conditions that may be associated with the likely diagnosis.

Treatment history: Details of past treatment (drug given/duration of treatment, compliance, and adverse effects if any, and if there was any response).

History of past illness: Typically, in episodic illness, only current episode is described in history of present illness and details of past episodes come here.

Family history: Record following information:

- 3 generation genogram
- Family history of medical or psychiatric disorder (psychosis, bipolar disorder, depression, suicide, substance use, dementia). The diagnosis may not be clear, describe the symptoms and behavioral disturbances, and record their treatment history if available (for e.g. family history of response to lithium may predict good response to lithium in this patient also).
- Record current living arrangement and who is primary caregiver
- Record family understanding of illness and attitude towards the patient also record any family stressors, interpersonal difficulties.

Personal History

- Antenatal history and birth complications
- Developmental milestones
- Childhood history for enuresis, nail biting, school refusal, truancy, conduct symptoms, ADHD, temper tantrums.
- **Schooling history:** Record average academic performance, last class studied, grades/marks in 10th and 12th standard and reasons for drop out.

- **Occupational history:** Jobs held, performance, reason for loss of job. Ask specifically for any frequent job changes, disturbances in work, etc.
- **Marital history:** Record for duration of married life, nature of marital and sexual relations, marital discord if any, details of family of procreation.
- **Sexual history:** Check for sexual misconceptions, high risk sexual behavior
- Menstrual history in female patients.

Premorbid Personality

- Ask about the individual's attitude to work/family, ability to take responsibility, coping when faced with stress, hobbies and interests prior to onset of illness.
- Individuals' social relations and interpersonal relationships need to be enquired.
- Patients' premorbid mood states should be enquired. In case of any issues, it needs to be evaluated in detail for any specific personality traits or disorder.
- Premorbid functioning—whether well-adjusted or had any kind of dysfunctions needs to be documented.
- In young adults/adolescent's temperamental history needs to be taken.

ESTABLISHING RAPPORT

i. Establishing rapport is probably the most important step in history taking.
ii. Especially when interviewing psychotic patients with poor insight, eliciting personal information like interpersonal issues, sexual history, sexual abuse, etc.
iii. Introduce yourself and set the agenda of the interview by stating that you would be asking questions to understand reason for consultation/admission.
iv. Address the patient by name—this is a useful to gain the trust of the patient
v. Ensure confidentiality by making explicit statement that information discussed will not be revealed without consent.
vi. Always interview the patient first and get her version of the history. This is also vital in cases where patients have poor insight and psychopathology involving the informants.
vii. Start with neutral questions such as occupation, education, family details, whether they are comfortable in the ward, etc.
viii. Begin with open ended questions such as 'what brings you to the hospital?
ix. Note the presenting complaints with duration in chronological order
x. Elaborate on the chief complaints by directive questioning.
xi. Use close ended questions (Yes/No) for eliciting specific information and negative history
xii. Use paraphrasing to make empathic statements
xiii. Follow the cues given by the patient and pick up leads for further questioning
xiv. Summarize at the end of the interview.

MENTAL STATUS EXAMINATION (MSE)

1. **General appearance and behavior**:
   a. Give a good observational description.
   b. General appearance and grooming
   c. Rapport—could be established/very easily established and overfamiliar/difficult to establish—guarded/hostile

d. Eye to eye contact—maintained/fleeting/hypervigilance/avoids/downcast
e. Any observed repetitive motor movements—tics/mannerisms/stereotypies/motor perseveration/catatonic signs.
f. Psychomotor activity—increase in goal directed activity/retardation, agitation, hand gestures while conversation, hyperactivity.

2. **Speech**
   a. Tone (loudness) of speech—normal/increased/decreased
   b. Tempo (rate or speed) of talking—normal/increased/pressure of speech/decreased
   c. Volume (amount) of speech. Estimate words per minute—verbose/pressure of speech/decreased
   d. Prosody—emotional intonations of speech
   e. Reaction time—increased/decreased
3. **Mood:** Subjective mood: Ask—"how has been your mood for most periods of the day over the last one week"—give verbatim description given by patient. Describe quality, intensity, duration and diurnal variation.
4. **Affect:** Cross sectional observation of facial emotional expression, motor behavior, gestures, posture, speech
   a. Euphoric/irritable/depressed/anxious/perplexed/restricted/blunted or flat
   b. **Range:** Intact/restricted
   c. **Reactivity:** Preserved/absent
   d. **Lability** (rapid shifts of mood during interview)—present/absent
   e. Appropriateness to situation and congruency to though process
5. **Thought**
   a. **Form:** Obtain speech sample on a neutral topic. Assess for poverty of thought/poverty of thought content/circumstantiality/flight of ideas/tangentiality/loosening of associations and derailment/neologisms.
   b. **Stream:** Observe for flow and continuity of thought process—flight of ideas/prolixity/retardation/perseveration/thought block.
   c. **Possession**: Disorders of thought related to the ownership of thought. Thought broadcast—thought diffusion/thinking in unison/audible thoughts, thought insertion or thought withdrawal.
   d. **Obsessions**—describe if thoughts are repetitive/intrusive/irrational/ego dystonic/person's own thoughts. Also mention the form (ideas/impulses/images/doubts/ruminations) and content of obsessions.
   e. **Compulsions**—motor/cognitive
   f. **Content**
      i. Delusions: Give verbatim description given by patient and then give your impression whether belief is—fixed/firm/false/not in keeping with socio-cultural background/morbid origin. Describe content of belief (persecutory/referential/misinterpretation/grandiose/hypochondriacal, etc). If there are multiple delusions also describe whether they are: Single/multiple elaborate/non-elaborate bizarre/non-bizarre systematized/non-systematized.
      ii. Overvalued ideas
      iii. Depressive cognitions—hopelessness/worthlessness/helplessness
      iv. Death wishes or suicidal ideation: Describe frequency, intensity of ideas and whether there are any active plans
      v. Preoccupations and ruminations—somatic/anxious/depressive

6. **Perception:** Give verbatim description of quality and content of perception given by patient and then give your impression whether the phenomenon: Occurs in clear consciousness/clear and vivid/objective or subjective space/patient has insight into it/control on the experience and give your impression whether the perceptual abnormality is a hallucination/pseudohallucination/imagery and which modality it occurs in. Describe phenomenon such as somatic passivity/depersonalization/derealization in heading of perception.
7. **Cognitive function assessment**
   a. Consciousness: Alert/drowsy but arousable with minimal stimulus/obtunded arousable with deep stimulus/stuporous
   b. Orientation:
      i. Time: Ask approximately what time of the day it is now without looking at the time (approximation should be within ± 2 hours).
      ii. Place: Ask patient to identify his surroundings and which place he is in
      iii. Person: Ask whether patient can identify himself and then people around him.

      Note: Patient should be alert and well oriented to proceed for the remainder of cognitive function assessment.
   c. Attention: Digit span test: Give serial digits sequences and ask patient to repeat them after you have presented the sequence. Numbers should be read clearly and rate of 1 number per second. First complete the forward sequence then present the backward sequence. Normal range of digit forward is 7 +/– 2 (5 to 9) and digit backwards is 5 +/–2 (3 to 7).

      Forwards Backwards

      7–4–9 1–7–4

      8–5–2–7 5–2–9–7

      2–9–6–8–3 6–3–8–5–1

      3–8–1–5–9–2 5–2–9–1–7–4
   d. Concentration: Serial subtraction test: Ask patient to perform 100 minus 7 in 2 minutes, 40 minus 3 in 1 minute and 20 minus 1 in 20 seconds. More than 2 mistakes are taken as abnormal. Illiterate subjects can be asked to name days of week backwards (They should be able to tell the backward sequence correctly for 5 steps starting from Friday).
   e. Language:
      i. Spontaneous speech and fluency (animal naming test—number of animals patient can name in 1 minute).
      ii. Comprehension: Verbal commands/pointing questions/multistep commands.
      iii. Naming: Naming common objects such as pen, coin
      iv. Reading and writing

      Note: If attention and language is impaired the interpretation of the rest of the tests of cognitive assessment is doubtful.
   f. Memory
      i. Immediate memory: Digit span test/serial subtraction test as above or 3-word registration. Instruct patient that you will be giving 3 words which

they should listen carefully, repeat them after you have said them and try to remember them as you will be asking them to recall it later. The three words should be unrelated and not present in the room, e.g. lotus, cat, blue.

ii. Recall: Ask patient to recall words after 5 minutes. Note if they require a cue to recall/confabulation. Alternative address test may be used. Give an address with 5 points to remember and assess recall after 5 minutes. For example: # 215, 9th Cross, 2 Main, Vijay Nagar, Bangalore.

iii. Remote: Ask if person can recollect personal information like marriage, child birth, schooling, occupation and semantic information like year of independence or events of national importance.

g. General information: Common knowledge such name of local rivers, important towns in your area, important personalities. This question is very subjective and needs to be asked based on education and socio-cultural background of the patient.

h. Calculation: Assess for simple calculation abilities, both verbal and written—addition, subtraction, multiplication, division. Arithmetic problem-solving questions (e.g. if you go to a shop and buy chocolates. Each chocolate costs 50 paise. How many chocolates can you buy for 4 rupees? If you have 20 rupees with you and a banana cost ₹7. How much money will you have left?).

i. Abstraction: Describe whether the responses are abstract/semiabstract/concrete.
Test for differences between pairs of objects (stone and potato, chair and table). Test for similarities between pairs of objects (orange and apple, bird and aeroplane). Ask to tell a proverb in his own language and the real meaning of the proverb. If patient cannot recall, give him some proverbs in his own language and ask for meaning.

j. Intelligence: Make an estimate of overall intelligence level based on comprehension, general information, calculation, abstraction and judgment.

8. **Insight**
   a. Awareness: That experiences are out of the ordinary/not real or normal/deviant
   b. Attribution: To psychological/somatic causation for the experiences
   c. Acceptance of treatment for the same
   Also grade insight from 1–6.
      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 blaming it on others, on external factors, or on organic factors
      4. Awareness that illness is caused by something unknown in the patient
      5. Intellectual insight: Admission that the patient is ill and that symptoms or failures in social adjustment are caused by the patient's own particular irrational feelings or disturbances without applying this knowledge to future experiences.
      6. True emotional insight: Emotional awareness of the motives and feelings within the patient and the important persons in his or her life, which can lead to basic changes in behavior.

9. **Judgement**
   a. Test: Give specific responses and ask what would the patient do in these scenarios. (What would you do if you saw that your neighbor's house is on fire? What would you do if you saw that a child was crawling towards an open well?)
   b. Personal: Ask what is the patients immediate future plan after discharge from the hospital
   c. Social: Impression of judgment is made based upon history of behavior over last one week and cross-sectional observation.
10. **Bio-drives**
   a. Sleep: Initial/Middle/Terminal insomnia, fragmentation
   b. Appetite: Reduced/Increased compared to his usual self
   c. Energy: Reduced/Increased compared to his usual self
   d. Libido: Reduced/Increased desire

Interview Techniques in Psychiatry

The psychiatric interview is the cornerstone of diagnosis and therapeutic engagement. It requires skill in both eliciting information and building rapport. The following techniques help structure and enhance the quality of clinical interviews:

1. Open-ended questions: Begin with broad questions (e.g. "Can you tell me what brings you here?") to allow spontaneous narration.
2. Active listening: Maintain eye contact, use nods and brief verbal affirmations to show attentiveness and empathy.
3. Facilitation: Gentle verbal or non-verbal cues that encourage the patient to elaborate (e.g., "Go on," or leaning slightly forward).
4. Clarification: Ask for clarification when responses are ambiguous ("When you say you feel low, what exactly do you mean?").
5. Reflection: Restate the patient's words to show understanding and to encourage deeper sharing.
6. Summarization: Briefly summarize what has been said to ensure mutual understanding and smooth transition between topics.
7. Silence: Use pauses strategically; silence often allows patients to collect their thoughts and reveal more.
8. Confrontation (used carefully): Gently point out discrepancies between what is said and observed behavior.
9. Empathy and validation: Acknowledge the patient's feelings ("That must have been difficult for you").
10. Transitioning and closure: Move between themes smoothly and end the interview by summarizing, reassuring, and outlining next steps.

These techniques not only improve diagnostic accuracy but also strengthen the therapeutic alliance, laying the foundation for effective treatment and follow-up.

Interesting concepts to read in symptomatology, history-taking and MSE

1. Transference
2. Hypnopompic and hypnogogic hallucinations
3. Brain lobe function tests

SUMMARY OF SYMPTOMATOLOGY, HISTORY-TAKING AND MSE

a. The differentiation between symptoms and signs in psychiatry is blurred. The clinician relies heavily on the abnormalities noted during clinical interview to make the diagnosis since there are no laboratory tests or neuroimaging findings which are helpful in psychiatric diagnoses.
b. The abnormalities of the mind are broadly in the field of thinking, feeling, perception or behavior. Therefore, these aspects should be evaluated in detail.
c. Clinical interview in psychiatry is both diagnostic and therapeutic. Therefore, it should never be a hurried affair.
d. For a beginner, it is best to write the detailed note of abnormal experience of the patient in simple English rather than writing the technical terms.

QUESTIONS

1. **Define delusions. Discuss various types of delusions.**
2. **Define hallucinations. Discuss hallucinations in terms of various neuropsychiatric disorders.**
3. **Discuss rapport building in psychiatric examination.**
4. **Describe briefly cognitive assessment in mental status examination.**
5. **During psychiatric interview patient retains a constellation of ideas long after they have ceased to be appropriate. The term used to explain the condition is:**
   a. Perseveration
   b. Mannerisms
   c. Ambitendence
   d. Echopraxia
6. **Early in the psychiatric interview, it is important for the physician to:**
   a. Inform the patient of the fee
   b. Obtain details of any past psychiatric illness
   c. Let patients talk about what is bothering them
   d. Record the family history

7. A person who laughs one minute and cries the next without any clear stimulus is said to have:

a. Flat affect

b. Euphoria

c. Labile mood

d. Labile affect

8. A 32-year-old woman is seen in an outpatient psychiatric clinic for the chief complaint of a depressed mood for 4 months. During the interview, she gives very long, complicated explanations and many unnecessary details before finally answering the original questions. Which of the following psychiatric findings best describe this style of train of thought?

a. Loose association

b. Circumstantiality

c. Perseveration

d. Flight of ideas