American Handbook of Psychiatry

THE PSYCHIATRIC EXAMINATION

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Like the psychiatric interview, the psychiatric examination has changed considerably in the past 60 years. Once largely restricted to the examination of severe mental disorganizations, it has now become an extensive study of the whole personality, with special emphasis on thought contents and their accompanying emotions. Moreover, psychiatric examinations are no longer restricted to patients with severe mental illnesses. Although naturally varying in emphasis and detail with different patients, some psychiatric examination should now form part of every careful medical examination.

Introduction

More specifically the psychiatric examination may uncover significant data under any or all of the following headings:

1. Signs of psychological disturbances that are expressions of the patient's major illness, for example, organic brain syndromes or schizophrenic reactions.

2. Psychological factors that are (partially) causative of a major physical illness or that exacerbate it, for example, anxiety in a patient with peptic ulcer, essential hypertension, or angina pectoris.

3. Psychological reactions to the presence of another illness, for example, anxiety about his condition experienced by a patient with congestive heart failure.

4. Psychological factors that interfere with the patient's cooperation in treatment, for example, a denial of illness or a resentment of authority as represented by the physician.

In addition to studying psychopathology, the psychiatric examination should also encompass the individual characteristics and assets of the patient. Unfortunately the preoccupation of physicians with ill health sometimes leads them to neglect the healthy aspects of their patients. Yet the outcome of an illness is influenced fully as much by the patient's assets and strengths as by the nature or apparent severity of his symptoms or illness. Without some awareness of these assets the physician cannot expect to promote healing by his efforts.

Although modern psychiatric theory emphasizes the adaptations that patients make to life stresses, it is possible to take a harmfully one-sided view of the patient's symptoms by considering them exclusively as defenses. Such narrowness can lead to such absurdities as the explanation of a schizophrenic

psychosis as an “escape" from difficulties in living. The schizophrenic patient becomes psychotic because the stress to which he is subjected disorganizes his mental machinery. With this there may come some relief, but it is certainly secondary. Similarly a young man about to go to college may develop an incapacitating dermatitis a few days before his departure. The illness prevents him from attending college, which he did not want to do. But he did not become ill in order to avoid going to college; rather his dermatitis was an accompaniment and an effect of the anxious thoughts connected with going to college. Many symptoms have adaptive or defensive value, others do not.

Therefore, psychiatric symptoms may be: (1) disorganizations or disorders directly produced by a lesion or acquired during a stress; (2) efforts to compensate for these disorders; or (3) efforts to counteract the lesion or stress.

The psychiatrist should remember that his examination may not elicit adequately representative data. This point deserves brief discussion. In a manner quite impossible for the physical state to do, the psychological state can vary widely with changes in the external environment. Two physicians may obtain totally different evaluations of the same patient’s mental state. The patient may have different feelings and attitudes toward each; he responds differently to the two different examiners, and consequently they observe different data in their examinations. For example, if the patient’s

attitude toward one physician carries unpleasant tension, this tension may impair his mental efficiency. A patient of greater than average intelligence may thus appear intellectually subnormal when his mental efficiency is momentarily so reduced. Another physician, evoking a different response from the patient, might conclude that the patient was highly intelligent. These discrepancies can occur even when the patient consciously wishes to cooperate with both physicians. Although the patient's attitude toward the physician depends partly on the approach of the physician himself, it is also influenced by the distorted perceptions of the physician by the patient, who may misperceive him as resembling some similar past significant person more than he actually does. In addition, the physician usually is a stranger and, in this instance, a person with some authority to make important decisions relative to the patient. Any observer of human behavior, by his mere presence, may modify the very behavior that he would like to observe.

A difference in the evaluation of the mental state may arise not only from differing attitudes of the patient toward different observers; equally the patient's emotional state may be changed by some other person or event, the effect of which may linger for many hours or days and may still be affecting him at the time of the examination.

Furthermore, the patient's anxiety may be aroused by the examination itself, altogether apart from the thoughts he has about the examiner. Some of

this anxiety may be rational; for example, he may know that the physician may make important recommendations about him (such as admission to a hospital) as a result of the examination. Or the anxiety may derive from quite irrational ideas about the examination; for example, the patient may believe that the physician has been hired by the FBI to trick him. Whatever its origin, anxiety about the examination can markedly alter the patient's mental status as observed during it.

The occurrence of important variations leading to lack of reliability in psychiatric examinations is not just a surmise. A number of tests of the reliability of psychiatric examinations have shown clearly that psychiatrists do not yet have anything like as fine a tool as they need in their current procedures of psychiatric examination. An awareness of these limitations may help to reduce them, and we shall therefore briefly review some investigations of the reliability of the psychiatric examination.

In considering reliability we must first acknowledge very different incidences of the diagnostic categories assigned to supposedly comparable groups of patients in different countries and even in different American hospitals. Although the reported incidence of schizophrenia in North America is two to three times the incidence reported for Europe, there is little evidence for believing that the true incidence rates would differ so widely if judged by the same physicians utilizing the same criteria. Studying the

records of New York State psychiatric hospitals, Hoch and Rachlin found marked variations in the assignment of the diagnosis “manic-depressive psychosis" over a period of some years. They also reported marked differences in the incidence of this diagnosis between New York and California State hospitals over the same period. Differences of the magnitude reported were almost certainly not due to differences in the incidence of “real disease" over the period studied or in these two states. It is much more probable that the difference derived from variations in methods of examination and in diagnostic criteria.

The observations of Temerlin indicate rather clearly that clinicians’ diagnoses may be markedly influenced by suggestion and the theoretical bias of the group or professional milieu in which they practice. Other studies suggest that psychiatrists and other mental health professionals tend to perceive members of different social classes quite differently and hence to observe and emphasize different features of behavior in patients coming from social classes different from their own.

When different examiners conduct independent interviews, one source of unreliability lies in the different ways in which the examiners conduct the interview. Two equally skilled examiners may elicit markedly different data from separate interviews with the same patient. Even when two examiners conduct a joint examination of the same patient, their individual perceptions

and formulations of the identical data may lead to considerable disagreement. Ash's studies of reliability of categorizations based on data derived from a conference method of examining patients are illustrative. Agreements for major diagnostic categories among paired psychiatrists ranged from 57.6 per cent to 67.4 per cent and, for specific diagnostic categories, from only 31.4 per cent to 43.5 per cent. These results suggest a rather low order of agreement.

If psychiatrists have cause for embarrassment in the rather low reliability of their examinations, they may derive some consolation from noting that equally large errors in history-taking for physical symptoms may occur. Cochrane, *et al*., observed that different physicians recorded markedly different incidences of pulmonary symptoms in coal miners interviewed under similar circumstances and presumed to have the same actual incidence of the symptoms that were inquired into. Serious discrepancies have even been found in the actual physical examination of patients and interpretations of laboratory examinations by different examiners. Summaries of such errors by Johnson and Kilpatrick provide some solace in suggesting that we are not alone among the medical specialties in the impreciseness of our current diagnostic skills. Perhaps the honest recognition of the limited nature of our current knowledge and clinical skills is essential to the eventual development of a more precise science of human behavior. Progress may eventually come with the development of more uniform systems of examination the use of similar check lists by different examiners, which will insure collection of more

comparable data,- and the further development of partially quantitative rating scales for the assessment of subtle changes in human behavior.

In the meantime, however, the psychiatrist should remember what we now know about the various causes of discrepancies between his examinations of the same patient at different times and between his examination at any time and that of a colleague at the same time or another time. He needs to remember that the patient's mental state at the time of an examination may be importantly influenced by: (l) alterations in the patient's psychological state induced by recent events; (2) the attitude of the patient toward the examining physician; (3) the attitude of the patient toward the examination itself; (4) the attitude of the examining physician toward the patient.

Thus discrepancies in the observations of different physicians do not always reflect different percipiences in the physicians. They can arise from changes in the patient's psychological state between one examination and another. The physician should therefore make his first examination as complete as possible, but he should also supplement his observations with the evaluations of other individuals, for example, nurses, occupational therapists, aides, members of the patient's family, who have had an opportunity to observe the patient in varying settings. And he should himself make repeated observations of the patient's behavior, if possible, in different

settings. Like the history of physical examination, the psychiatric examination should be a continuing process in which the physician is ever observant of new data.

The psychiatric examination, as well as the physical examination, requires evaluation by two standards. In some respects all healthy human beings resemble each other, and gross deviations from statistical normality may be safely labeled abnormal. In evaluating such deviations the physician relies upon a broad knowledge of human nature and human behavior in the culture in which he and the patient live. But he must also remember that in some respects everyone is unique. For these aspects the patient himself furnishes the standard of reference. The physician should therefore try to compare the patient's present condition with his premorbid level of function. Only in this way can he accurately evaluate the patient's mental state.

Sometimes the patient himself can reliably contribute information about his "base line." However, the physician rarely knows the patient's dependability in this regard, at least initially, and so should check the subject's statements with those of others who have known him closely. The patient's relatives and friends can often provide valuable information about the extent of deviation from his usual personality.

Before presenting an outline of the psychiatric examination we think it

important to remind our readers that psychological states have a wholeness the existence of which we can obscure by our habit of examining part functions. We cannot avoid examining parts, but we can reduce the attendant errors by constantly remembering the interdependence of the parts on each other and the quality that is given to each part by its membership in the whole. For example, we sometimes differentiate intelligence from personality, as if these two words denoted exclusive functions. Actually the qualities included in the concept of intelligence, far from being separate, form a major part of personality. Personality may be defined as the sum of the habitual reactions of a person to external events. Perceptions, intellectual functions, and affective states all influence these reactions. We may usefully abstract for our discussions the processes of perception, integration, and response; in life, however, they merge inextricably. Almost any item of behavior may illustrate the instantaneous blending and the impossibility of really separating these processes. For example, suppose the patient angrily accuses the physician of not being sufficiently interested in him. He reveals his misperception of the physician as being similar to his neglectful father and dissimilar to his adoring mother. At the same time he shows his inadequate understanding of the physician's role and usefulness and of the physician's genuine interest on his behalf. Such understanding might have corrected, to some extent, his initial false perception. He also shows how his own comfort depends upon the interest and affection of other persons, and how threatened he feels when this

is lessened. Finally his anger shows the pattern of his response to this anxiety and his lack of inhibition of the expression of his anger.

A mental examination reveals order or disorders of function. The physician does not examine a mental organ directly in the same manner that he can examine a physical organ, for example, when he auscultates the heart and lungs. His examination of the mental state cannot even be as direct as the examination of nervous tissue. In the latter case the nerves are not seen and rarely are even felt. Disturbances of their function are usually deduced from noting changes in the activity of other organs, for example, the muscles. Similarly in the mental examination the physician infers disturbances by noting abnormalities in the way the patient perceives, integrates, and responds to external events. He cannot observe the mental processes directly. He must deduce their condition from the patient's verbal statements and from observations of his other behavior.

Before describing the psychiatric examination itself we wish to emphasize the importance of placing it within a comprehensive examination of the whole patient. This should include a careful history of the patient's physical health together with a physical examination and all indicated laboratory tests. The interrelationships of psychiatric disorders and physical ones are often subtle and easily overlooked. Each type of disorder may mimic or conceal one of the other type. For example, an important percentage of

patients diagnosed as psychoneurotic have been found later to have significant physical illnesses that accounted for their symptoms. A large number of brain tumors and other diseases of the brain may present as “obvious" psychiatric syndromes, and their proper treatment may be overlooked in the absence of careful assessment of the patient’s physical condition. The psychiatrist cannot count on the patient’s leading him to the diagnosis of physical illness. Indeed, patients with psychiatric disorders often deny the presence of major physical illnesses that other persons would have complained about and sought treatment for much earlier. In addition to the aid in actual diagnosis that physical examinations afford, they may also help in the assessment of the gravity and potential dangerousness of the patient’s condition. In this connection electroencephalograms have proven increasingly helpful in distinguishing patients inclined to express aggressive impulses violently.

Outline of the Psychiatric Examination

We shall next present an outline of the psychiatric examination, arranged in headings for easier memorization. Then we shall discuss individual parts of the examination. We offer this outline without any conviction that it surpasses all others. The value of an outline lies chiefly in the prevention of omissions in the examination, and one outline may accomplish this as well as another. Certainly we should use no outline rigidly

in our own thinking and even less in our examination of the patient. Each examination should differ from every other, according to the needs of the patient and physician and other circumstances. However, our advocacy of flexibility does not condone casual or incomplete examinations. As mentioned earlier, details and emphasis will vary from one case to another, but in every instance the psychiatrist should consider, at least in his own mind, each of the major headings of his outline. Most errors arise from omissions, relatively few from faulty observations. Sometimes circumstances prevent as adequate or as complete an examination as we wish or the patient's condition requires. When this occurs we should record the deficiency in our notes and never fail to remedy it as soon as conditions change.

The outline presented here has three main sections that correspond, so to speak, to the afferent, central, and efferent portions of a reflex arc. However, because the patient presents his emotions and behavior first to the observation of the examiner, we have placed these first. The physician can often complete this part of the examination during his interview with the patient. Through transitions that we shall mention later, he can then extend the interview into the more detailed examination of the other parts of the outline.

Outline of Psychiatric Examination

General Observations

- Circumstances and setting of examination
- General description of the patient

Emotions and Behavior
  Emotions
  Behavior, with special emphasis on potential for destructive behavior
Central Organizing Processes
  Intelligence, including memory
  Thought processes
  Thought contents, including self-concept and insight
Perceptions
  Misperceptions
  Illusions
  Hallucinations
  Attention
  Orientation

General Observations

In addition to the usual note about the date and place of the examination, the physician should also make some mention of the actual setting in which the examination was conducted. As previously noted, human behavior may differ markedly in different surroundings and under varying circumstances. Strange surroundings, or those that might be interpreted as threatening, may induce such severe anxiety as to obscure other important aspects of the patient's psychological state. The setting and circumstances of the examination therefore acquire their importance from the effect they might have on the patient. Any unusual reasons for making an examination—for example, at the request of a court—other than the patient's request for medical assistance should also be noted.

The physician should next attempt something akin to a novelist's sketch of the patient, using a photograph of words to convey a meaningful picture of the patient as a person. As Francis Peabody- once stated aptly, ". . . a 'clinical picture' is not just a photograph of a man sick in bed: it is an impressionistic painting of the patient surrounded by his home, his work, his relations, his friends, his joys, sorrows, hopes and fears" (p. 15). By way of illustration such a description may include the general appearance, demeanor, and clothing of the patient. A female patient who enters the office with hair unkempt, little or no makeup, no stockings, and badly scuffed shoes immediately communicates something about her attitude toward the social norms of dress. What this format means for her (for example, defiance of social customs, hostility to men, or lowered estimate of herself) will only emerge later, but its occurrence should be noted immediately.

To this general description the physician should also add a note concerning the patient's initial attitude toward the examiner, the interview, and the examination, his expectations about these, and his degree of cooperativeness.

Emotions and Behavior

Emotions

If the psychiatric interview is sufficiently complete and ranges widely

enough to permit full expression of the patient's emotions in connection with the topics of major significance to him, the emotional content can often be quite adequately evaluated during the course of the ordinary history-taking interview. Chapter 53 having discussed this extensively, we shall not here fully consider this aspect of the psychiatric examination.

Dominant Emotions.

The physician should observe the dominant emotions of the patient, their intensity and duration, and their appropriateness to the patient's immediate situation and thought content. The physician should know whether a dominant emotion has recently arisen or is habitual, and hence more properly called a mood. Sometimes he may watch emotions come and go during an interview and thus gain information about the capacity of the patient to return to his habitual feeling state; at other times he may need to make special inquiries on this point. Thus lie may obtain considerable information about the lability or fixity of the patient's emotional life. He should also learn about the sensations experienced during a given emotion. Some persons have only mild changes of sensations during emotions such as fear and anger; others may undergo what amounts to a severe physiological storm.

Events acquire meanings through the quality of our experiences. As

different experiences give different meanings to outwardly similar events, we must always learn the meaning of events for the patient. When we observe a strong emotion in the patient, we know that we have reached something important for him, but why it is important we learn only from getting him to tell us about his thoughts and feelings. As the patient is frequently a poor witness of his own thoughts and feelings, we can often help him and ourselves to a better understanding of his emotions by learning what situations evoke the various emotions in him.

Since much human behavior and a great deal of psychopathology derive from efforts to control or suppress the expression of strong emotions, the study of the patient's various mechanisms for dealing with emotions forms a most important part of every psychological evaluation. Does the patient handle emotions such as anxiety in an integrative and constructive fashion? To what extent have the patient's efforts at controlling or concealing emotions succeeded, and to what extent have they failed? If they have failed, to what extent has the patient's mental organization become impaired?

To summarize and illustrate, if the patient is angry, the physician needs to know what has provoked his anger, why this angers him, how he feels, what he shows, and what he does when he is angry.

When the psychiatrist notices an important durable emotion, such as a

depressed or elated mood, he should carefully evaluate the degree of mood change and its present or potential connection with irrational and perhaps dangerous behavior, for example, suicide in depressed patients or wild financial schemes in elated ones.

Appropriateness of Emotions.

In evaluating the appropriateness of emotion to a given situation, the physician should remember the following modifying factors:

Cultural Differences in Emotional Expression. Wide variations in patterns of emotional expression occur. To the Scandinavian the Italian may appear wildly emotional, while the Italian may think the Scandinavian cold and unfeeling. The physician must therefore know the patient's customary or cultural pattern of emotional expression before evaluating its appropriateness.

Suppression and Concealment of Emotion. When the patient feels ashamed of his emotions or has other motives for their concealment, his emotional reactions to stressful situations may seem inappropriate.

Masking of Other Emotions by a Dominant Emotion. Any strong and lasting emotion can dominate the experience of the patient so as to exclude other emotions from expression in situations that might ordinarily evoke

them. For example, a patient extremely anxious or depressed will not smile or cry when stimulated by events that would previously have made him do so. A general decline in all emotional expression, known as apathy, can similarly exclude ordinary emotional expression.

Displacement of Emotional Expression Toward an Inappropriate Person or Object. A person may inhibit the discharge of a strong emotion toward the person stimulating it and later discharge a similar emotion toward someone else who perhaps precipitates a slighter degree of this emotion but receives the full force of the accumulated earlier emotion. Misperceptions of other people may also lead to inappropriate expectations of them and hence to inappropriate emotional reactions. Such misperceptions probably account for most inappropriate emotional responses. Their frequency emphasizes the importance of observing the roles that the patient assigns to himself and to others. Significant clues to these perceptions may often be found in the patient's emotional reactions to the examining physician.

Inappropriateness (apparent or real) of emotion to thought content may arise in a number of ways.

Unawareness of Actual Thoughts. The psychiatrist may be unaware of the patient's actual thoughts. First, the patient may conceal his thoughts. Second, he may reveal them but the physician may not understand the special

significance that they have for the patient. A patient with a schizophrenic reaction may smile or laugh as he mentions the death of his father; however, we may find that the father was a tyrant whose death brought joyful relief to the patient. Third, the patient's thoughts may move so quickly that the physician may observe the occurrence of an emotion but fail to detect its accompanying thought. Apparently inappropriate emotional expression also occurs in schizophrenia as a result of disrupted associations. In talking about something that is quite serious, the patient may be observed to smile or laugh in a manner quite inappropriate to the topic under discussion. Upon being questioned about this, however, the patient may state that an amusing thought entered his mind at the time he smiled. Thus again the emotion expressed in the smiling may have been quite appropriate for the thought. The abnormality lay in the intrusion of this thought at this time, a result of the disorder in association that is a characteristic feature of this condition.

Dissociation Between Thoughts and Emotions. The central abnormality here is not that meanings have changed but that thoughts no longer bring the usual accompanying emotions. This kind of dissociation can often be observed in dreams in which, for example, situations that would be quite alarming or quite ludicrous to the waking consciousness fail to evoke anxiety or laughter. When this condition is found in the waking state, it strongly suggests a schizophrenic disorder.

Neurophysiological Disorder in the Expression of Emotions. In certain brain diseases, such as pseudobulbar palsy, so many cortical neurons are injured that an interference occurs with the modulation of emotional expression. Accordingly, a slightly amusing thought brings a shower of laughter, and a sad thought may precipitate tears. The patient usually knows that his emotions are excessive and inappropriately expressive of his thoughts, but he cannot control these reactions.

Behavior

Emotion and behavior overlap and merge and are to a considerable degree interrelated. Behavior generally refers to action and expression with the whole body or major parts of it. Behavior may express the same motives as those that give rise to the conscious experience and expression of emotions. On the other hand, a given attitude may not enter conscious awareness as a felt emotion but, nevertheless, may reach expression indirectly in behavior. For example, if a wife slights her husband, he may not experience conscious anger, but if he forgets his wife's birthday the next day, we might be justified in attributing this forgetting to a hostile motive provoked by his wife's remark. Or the husband, still without showing any anger, may bring into play techniques for making his wife feel guilty. He thus retaliates not openly but by a much more subtle hurting of his wife.

In evaluating the expressive and communicative significance of motor activity, it should be noted that some motor activity is a concomitant of a central neural state. The communicative aspect of this kind of activity is incidental and only medical. It may tell the physician about a central disorder, but it is not created for this purpose. Other motor activity has communicative intention but is not symbolically expressive. And still other motor activity communicates symbolically to those who understand the symbols. Thus we may observe motor activity of the hand in a kind of gradient of communicativeness, as follows:

1. Tremors of the hands associated with organic diseases of the brain, for example, Parkinson's Disease. The symptom is a concomitant of a disturbance in the central nervous system, having only a medical communicative value.

2. Tremors of the hands associated with anxiety states. No communication is "intended," but some may result if the tremor is noticed by those who can interpret its significance.

3. Tapping of fingers on a table during partially inhibited anger. Here the motor activity is partly an accompaniment of heightened psychological tension but also may have, and be intended to have, communicative value to other persons.

4. Banging the fist against a table. In this act the patient communicates symbolically his anger and his desire to hit another person.

The physician should note the patient's general level of physical tension. Is his activity random and unorganized, or is it channeled into some constructive project? Is he aware of periods of hyperactivity or hypoactivity, and do these disturb him in any way? Is he prone to act out or express his frustrations and anxieties directly through various behavioral outlets? If so are these techniques successfully adaptive or self-defeating? Can he communicate readily with words, or does he communicate chiefly with nonverbal behavior?

The behavior of the patient with other people and the effect he has upon them are of major importance in making a comprehensive psychological evaluation. One should note, for example, those persons with whom he shows anxiety, those toward whom he feels superior, those of whom he stands in awe, and those to whom he comes for help. In a similar vein does the patient evoke pity, anxiety, anger, attention, friendliness, or aloofness in most of the people he encounters? If so is this a habitual, chronic pattern or one of recent development?

Any study of the patient's interpersonal relations should certainly not be limited to simple observations of his interaction with different persons. Although the patient's behavior with different people varies, he is a unique person with certain needs that dominate his behavior and give it a more or less consistent pattern. One basis for the concept of personality is that there

are habits and patterns in behavior that give some predictability to each person's responses to his environment. Therefore, the physician should try to detect the dominant traits of the patient, or his recurring patterns of activity, as expressed in his behavior with different people. Such traits as ingratiation, aggressiveness, cautiousness, defensiveness, and irritability will occur as leitmotivs over and over again in the patient's behavior with many different people. The major generalizations that he has made from his past experiences thus become expressed in the recurrent traits of his behavior in relations with other persons.

Potentiality for Destructive Behavior.

The patient's potential for destructive behavior, whether directed toward himself or others, should be considered and recorded. Although determinations of suicidal and homicidal risks are paramount, other more subtle forms of life-threatening behavior, such as chronic alcoholism in a patient with known liver damage, drug addiction, pathological risk-taking, and persistent accident proneness, should also be considered.

Since depressed patients have the highest incidence of suicide, it is appropriate to consider the detection of suicidal risk in connection with depression. However, since suicidal behavior is frequently encountered in many other diagnostic groups, such as chronic alcoholism and schizophrenia,

a consideration of suicidal risk should not be limited to the depressive group. Helpful data for this evaluation may be derived from observation of the patient's nonverbal behavior, dominant emotion, and thought content. The examiner should also interrogate the patient directly, albeit gently, about any thoughts of suicide he may entertain.

The possibility that an occasional patient may constitute a risk to others should also be kept in mind. Individuals with clinical signs of organic brain damage and a history of episodic dyscontrol and violent rage constitute a special risk. Other patients showing highly organized delusions of persecution, relatively intact intellectual processes, high levels of energy and aggression, weak self-controls, and a history of responding to anxiety with overt aggression deserve special note. Unfortunately most patients who fall within this category are rarely referred for psychiatric help until they are involved in serious legal difficulty.

Potentials for destructive behavior, whether it be suicide or compulsive kleptomania, can only be evaluated and recorded in terms of probability. For purposes of concise recording, some clinicians have recommended a three-point continuum or scale on which the behavioral potential is noted to be either absent or minimal, definitely present or a major risk. Cohen, *et. al.,* have developed a 14-point check list for suicide risk that takes little time to fill out and assures that the main features of the patient's condition that increase the

risk of suicide are all considered. Whether check lists and scales are actually employed in evaluating the potential for destructive behavior, it is essential that a systematic assessment of such potentiality be made in every patient whose condition suggests its presence.

Central Organizing Processes

Under central processes we include all those mental processes that occur between stimulus and response; that is, everything mental that contributes to the organization and utilization of experience. For purposes of study and discussion the processes may be divided into a number of topics, such as intelligence, thought processes, and thought content.

INTELLIGENCE

Intelligence is a term applied to a number of mental components and processes, including speed and accuracy of thinking, richness of thought content, capacity for complex thinking, and the ability to manipulate thoughts and objects. Standardized tests of intelligence administered by clinical psychologists can often provide useful information to the psychiatrist. Sometimes, however, poor cooperation on the part of the patient or other factors result in test results indicating an intelligence lower than that actually possessed by the patient. Even when he has the aid of a clinical psychologist and always when he has not, the psychiatrist should make his own appraisal

of the patient's intelligence. In evaluating the patient's intelligence he should take into account the history and also the following factors;

Vocabulary and Range of Information.

Both of these functions may be demonstrated during the course of history-taking interviews or other parts of the examination. Care should be taken to avoid confusion between intelligence and formal education.

Memory.

The accuracy and extent of the patient's memory for the more remote past can usually be determined from his account of childhood and earlier life given in the history- taking interviews. Recent memory will usually be revealed in the patient's account of the events of the immediate past, such as the circumstances just prior to the examination. The importance of memory in behavior requires the careful examination of the patient with regard to any defect discovered. Do gaps of memory begin and end abruptly? Are they confined to one period or scattered over the whole span of life? Do they include unpleasant events only or pleasant and unpleasant ones indiscriminately? Is the defect of memory due to lack of attention to the environment or to poor retention or recall? Does the patient know he has a poor memory? Does he fill in gaps in memory with confabulations or compensate with garrulity?

Judgment.

By judgment is meant a person's ability to use all the resources of his intelligence in solving constructively the problems that he meets. Although behavior supplies the only really reliable guide to judgment, some information about the patient's problem-solving techniques and the kind of decisions he makes may be derived by posing for him certain hypothetical dilemmas.

Thought Processes

Although the processes of thought are chiefly evaluated through the patient's speech, other indicators, such as drawings and special tests, may be employed. In general, one may assume a rather close correlation between the patient's speech and his thought content. Certainly speech expresses thought, but it often does so imperfectly. Some patients, such as those who are shy or uncooperative, may hide behind their few words an initially unsuspected clarity and richness of thought. And a smaller number of patients may acquire a verbal facility that successfully conceals blurred concepts and other limitations of thinking.

Speed of Thought.

The speed of the thought processes communicates valuable information about the patient. Some people think faster than others all their lives. This

greater speed of thought (often accompanied by greater speed of speech) may reflect superior intelligence rather than the mood of the person. The physician needs to know whether there has been a change in speed of thought and speech from what is habitual for the patient. If so this usually indicates a change in mood, since in elation thoughts and flow of speech are accelerated, and in depression they are retarded.

Besides changes in mood other circumstances may alter the speed of thoughts and speech. For example, in delirioid states and in schizophrenic disorders thoughts ordinarily held unconscious may invade consciousness. The patient may react to this increased imagery by attempts to describe it or to respond to it. The resulting increase in speed of speech may therefore indicate an increase in imagery rather than elation.

Accuracy and Clarity of Thought and the Capacity for Higher Forms of Thinking.

As the patient talks, the physician should study the organization of his productions. Various degrees of disorganization may be noted. The patient may talk in grammatical, well-constructed sentences, but these may bear little relation to each other, giving a lack of coherence to the whole; or individual sentences may be poorly constructed, disorganized, or asyndetic. Words may be fragmented, or new words may be invented. Such neologizing may result in words such as “bastitute," “incarsterate," and “mental teleprosy," whose

etymology and meaning are reasonably clear. The origin and meaning of other neologisms are often obscure, although they nearly always become intelligible through careful study of the patient and his past experiences.

The relation of individual sentences to each other may indicate some disturbance in associations. When associations are disturbed so that irrelevant thoughts intrude into consciousness, the disturbance is usually reflected in the speech. The interference may be manifest only as a blocking, so that the flow of speech becomes temporarily interrupted. This occurs commonly in states or moments of anxiety. The psychiatrist should note the topic about which the patient is talking at the time of blocking or hesitancy. The affect associated with the topic acts like sand in the mental machinery. Sometimes the intruding thoughts are themselves expressed, giving rise to more or less disorganization of speech. When every thought seems to be verbalized and all filtration of thoughts apparently suspended, the physician should suspect a psychotic disorder. A complete disinhibition of the expression of thought, that is, true free association, does not occur in a first interview or mental examination unless a severe mental disorder, for example, a dissociation, is present.

The examiner should note the ability of the patient to pursue a goal idea. When speech is accelerated, as in elation, thoughts often skip from one idea to another in what is appropriately called a flight of ideas. This rapid succession

of ideas may result in the expression of no central theme whatever, so that although the patient may appear to have some goal idea in mind, he never reaches it. The physician should note the patient's ability to pursue a line of thought during distracting stimuli. Can he continue a theme after he has been interrupted?

The examiner should try to understand the reasons for a patient's inability to reach a goal idea. Is his stream of thought interrupted by intruding thoughts or by extraneous stimuli? If intruding thoughts interrupt him, are they repetitive, obsessional thoughts or the products of loosened association? Or does the patient have one dominant thought content that crowds out all others?

The meaning of circumstantiality, in which the patient floods the psychiatrist with irrelevant detail, also deserves attention. Has the patient never learned to focus his thoughts, or does this symptom arise as a response to some anxiety? The patient may tell his story in great detail to win the psychiatrist's approval for "his side," or he may do this to avoid talking about something he wishes to deny or conceal. He may give much detail to evoke sympathy for his suffering, or he may be trying to substitute a wealth of other detail for important gaps in memory. Only careful study can clarify the distinctions between these motivational factors and disorganization of thinking due to organic brain disease.

The examination of thought processes should include study of the patient's capacity for conceptual thinking. Under this heading the physician should consider and, if need be, test the patient's ability to perform abstractions.

Rigidity of Thought Processes.

The human tendency to form habits affects not only behavior but thought itself, which is a foundation of behavior. Many serious difficulties in living occur because the patient cannot entertain alternative explanations of events or cannot consider alternative responses to them. Earlier associations and generalizations become hardened so that they cannot be broken down to make way for new associations or more appropriate generalizations. Under this heading one should, therefore, consider the extent to which the patient's mind is open to new ideas and thoughts. Is it closed to explanations and interpretations different from those he has worked out for himself? Or, on the other hand, is he abnormally suggestible and excessively liable to pick up the thoughts of others?

Thought Content

Central Themes.

From observations during the history-taking interview the physician

will usually have obtained much information about the main themes or central preoccupations of the patient's thoughts. However, judicious direction of the interview may be necessary in order to uncover central themes that are being avoided or unconsciously concealed. The examiner may be able to quantify somewhat the different values attached by the patient to different subjects by noting how frequently each comes up in the course of conversation. On the other hand, that which is obviously avoided or left unsaid frequently reveals as much about the patient as his overt verbalizations. Because affect is usually directly related to thoughts, central themes of thought should be correlated with the dominant affect.

Abnormalities of Thought Content.

Under this heading one should consider such symptoms as fixed ideas, phobias, obsessional ideas, delusions, and excessively unrealistic fantasies. The degree of distortion of thought content and the tenacity with which the patient maintains his distortions should be noted. To what extent does the abnormality of thought content influence the patient's behavior? Are his abnormal thoughts of recent origin or habitual with him? Do they create further anxiety, or is he blandly content in his current situation?

Self-Concept.

The set of thoughts that the patient entertains about himself and that en

bloc constitutes his self-concept is of the highest importance. What does he think about himself? Does he exaggerate or minimize either his assets or his deficiencies? Is his self- concept congruent with the way other people see him? Does he feel that he has undergone change or is in some way not his "usual self"? Does his self-concept match his ideal of himself? How would he like to change?

Insight.

Insight in this connection means the patient's understanding of his illness and the attendant circumstances. Some patients are unaware that they are ill; others feel sick without understanding what is going on; still others have some grasp of their illness but feel no responsibility for it, even blaming it altogether on others. The highest form of insight allows knowledge of how one's behavior affects others and implements constructive steps toward appropriate modifications. The physician should note the patient's feeling of responsibility for his situation, his awareness of how his behavior is affecting others, and his curiosity about his illness and its treatment.

Perceptions

Disorders of perception occur in a wide variety of forms and in various degrees of severity. The patient may incorrectly perceive either himself or the external environment. The physician should often inquire first about simple

variations in the intensity of perceptions, for example, hyperacousia, myopia, anesthesias, hyperalgesia, and so forth. Then he should inquire about the more severe disorders of perception. These may range, in approximate order of severity, from misperceptions of other people, through illusions and hallucinations, to states of disorientation and confusion. Intermediate disorders of perception, such as the hallucinations found in schizophrenic psychoses, seem to arise from a combination of motivational influences and the disruptive effects of strong anxiety on mental processes. The more severe disorders of perception, such as confusion and disorientation, are usually noted in the presence of serious interference with cerebral function such as that encountered in toxic states or structural disease of the brain.

Misperceptions

Simple misperceptions of the mildest degree consist of mistaking the role of another person, that is, expecting different behavior from him than he can reasonably be expected to show. These errors are usually based on past experiences, but they are also influenced by strong affects, especially fear. An example would be the patient's expectation that the psychiatrist will always treat him with tenderness and indulgence, just as his mother did when he was a child. To note misperceptions the psychiatrist should study carefully the patient's comments on different people and his behavior with them. He should notice especially, since he can observe it most easily, the patient's

behavior with the psychiatrist.

Illusions or Misidentifications

In the simple misperceptions mentioned above, the patient does not actually misidentify objects and people but only misunderstands their roles. In illusions perceptual misidentification of objects and people occurs. The patient then may mistake the psychiatrist for, say, his brother. The examiner should avoid confusing illusions and delusions. In a delusion, which is a false belief, the patient might think that the psychiatrist was his brother disguised skillfully to look like the psychiatrist.

Hallucinations

Hallucinations are sensory perceptions occurring in the absence of external stimuli. The following aspects of hallucinatory phenomena should be noted:

1. Sensory modality in which they occur.

2. Content of hallucinations, including resemblances of voices or visual appearances to those of persons known to the patient.

3. Circumstances associated with their occurrence or with fluctuations in their intensity.

4. The patient's insight into their occurrence and his reaction to them.

Does he communicate about them freely or does he conceal their occurrence?

Attention

By attention is meant the patient's ability to focus his consciousness on a part of the field of awareness. It may be compared to focusing vision on a part of the visual field. The examiner should consider attention with regard to the following aspects:

1. General direction, that is, toward outside stimuli or toward inner thoughts.

2. Concentration. Can the patient's attention be diverted from its main focus to other stimuli? Is it too easily diverted so that he cannot concentrate? Sometimes we can distinguish active attention, that which the patient directs himself, and passive attention, that which occurs without his interest or willed participation. A combination of inwardly directed and fixed attention is a feature of dissociated states, in which the patient attends largely or only to his own stream of thoughts and responds less or not at all to outside stimuli. He is then said to be "out of contact" with the examiner. This can exist in all degrees and many variations.

3. Clarity of attention. Clarity of attention may become impaired as during toxic interferences with cerebral functioning. This is often referred to as a clouding of consciousness. Clouding of consciousness is not necessarily a feature of dissociated

states. Clouding of consciousness can exist in all degrees from slight impairment to states of severe confusion merging into coma.

Orientation

In the more severe disorders of perception, orientation becomes impaired. However, orientation may be preserved in the presence of other severe disorders, such as hallucinations and dissociated states. Orientation is usually studied under the following headings:

1. Time—knowledge of the hour, day, date, month, season, and year;

2. Place—knowledge of one's location and spatial orientation.

3. Person—knowledge of one's identity.

Of the above three aspects of orientation the sense of time seems to be the most fragile and is usually the first to become disorganized as organic brain syndromes develop. Orientation for person is the most stable aspect of the three. It is worth noting also that the patient may give a correct statement about the place he is when he can no longer locate the place properly in relation to other areas. Thus he may answer in response to a question about orientation for place that he is in, say, the "University Hospital," but be unable to describe how he can go from the hospital to his home. At a later stage of disorientation the patient loses orientation for place as well as that for

location. Sometimes, we also consider under orientation:

4. Situation—knowledge of why one is in a certain place.

This includes correctly identifying the people around one and their functions. Defects of orientation for situation are usually delusions. Sometimes the phrase “paranoid disorientation" is used for them. The patient, for example, knows that he is in a hospital ward but insists that it has secretly been changed into a prison and that the doctors are guards.

The Technique of the Psychiatric Examination

The Approach to the Examination

We cannot and should not sharply separate the psychiatric interview and psychiatric examination. The psychiatric examination begins the moment patient and psychiatrist meet. As the patient talks during the history-taking interview, the psychiatrist should attempt to evaluate his emotional state, his intelligence, his thought contents, or any other function of the patient’s personality that may reveal itself. As the psychiatrist’s skill in mental examination increases, he will find that he can conduct more and more of his examination during the history-taking interview, leaving ever smaller portions for some specific inquiries at the end of the interview or for another occasion. Thus the experienced examiner can often guide a history-taking

interview so as to carry out a rather complete survey of the patient's mental state. On the other hand, errors can arise from careless reliance upon the history-taking interview as a substitute for a thorough examination, particularly in the hands of the inexperienced. Such deficiencies may occur if the psychiatrist fails to have the interview range over an area broad enough to provide all the data necessary for an adequate and comprehensive evaluation. The psychiatrist should not think that if he just keeps the patient talking, all the important data will simply fall into his ears. A great deal of essential material may be overlooked unless it is specifically sought, either by skillful direction of the interview or by specific and thoughtful questioning. In the course of such inquiry the examiner may use the data of an earlier part of the same interview or of another interview to guide his questions so that they will be most appropriate and most tactful.

Any change of emphasis in the interview toward more detailed or specific examination should be made as subtly as possible and preferably without the patient's even being aware of such a transition. The examiner who inadvertently makes the patient feel that he is being "tested" or interrogated as a witness may succeed only in confirming the patient's worst expectations about himself and the nature of psychiatric therapy. A clumsy approach may intensify the patient's anxiety so that he becomes unable to cooperate in the examination to any significant degree. Tactfulness in examination, apart from sparing the patient discomfort and additional

anxiety, may therefore add considerably to the information actually obtained.

The transition to more detailed examination of the patient can sometimes be made smoothly by an appearance of investigating the patient's complaints more thoroughly. For example, the psychiatrist can say, "You mentioned a few minutes ago that your memory was not working as well as it used to. I would like to ask you a few questions so we can see just how much trouble you have been having." Abnormal thought contents such as delusions can often be studied ostensibly as part of a more detailed review of the patient's history.

However, some topics of examination do not lend themselves to such exploration, and these the examiner will nearly always need to present with a brief explanatory comment. His questions should also tactfully attribute maximal function to the patient. The following questions illustrate such introductions.

"I suppose you keep pretty good track of time, don't you?" The patient answers, and the psychiatrist continues, "Would you know what the date is today?"

"Do you read the newspapers and keep up with current events?" The patient answers, and the physician continues, "In that case I am sure you'd know who the President is. Can you tell me?"

“You said you went to the eighth grade, I think. Would you mind if I asked you a few questions in arithmetic? They are quite simple."

“You said your memory was pretty good. Do you mind if I see just how good it is?"

“You’ve told me a good deal about yourself. Now would you mind if I asked you some more specific questions about yourself and how your mind works?"

If the patient makes no objections to the inquiries, the psychiatrist need volunteer no further explanation. If, on the other hand, the patient seriously hesitates, becomes uncooperative, or asks what is going on, he is entitled to a reasonable explanation. The psychiatrist may explain that, as the patient has evidently had some psychological symptoms (reference being made in passing to these), additional information is needed to find out what can be done to help. The examination should never be presented to the patient as a “test" in which what he does may be compared to what someone else does. Such an analogy may evoke memories of failures in school and anxiety-laden thoughts of inferiority, and such feelings may reduce mental functioning further or destroy cooperation. Instead, the examination should be explained to the patient as an effort to compare what he does now with what he once did, and with what he is believed capable of doing when he is at his best. But

it is altogether preferable if the examination can be accomplished with sufficient skill so that elaborate explanations are unnecessary.

The Importance of Not Humiliating or Tiring the Patient

Anyone can be chagrined by noting an inadequacy of function, especially a mental function, in relation to an assumed standard or to one's previous performance. The examiner should remember this especially with patients who are already somewhat aware of a loss of mental function as, for example, those with arteriosclerotic or other brain diseases. In such instances a few questions may quickly bring out some loss of intellectual capacity. The patient may well have managed to compensate partially for these defects by denial; if he is confronted with them through formal testing or insistent interrogation, however, the defensive denial may be torn from him with catastrophic results. Anxiety so aroused may impair function still more and can lead to further anxiety in a vicious cycle. Inquiries should therefore be pushed only far enough to reveal information needed for the evaluation and eventual well-being of the patient. As always the emphasis should be upon the welfare of the patient and not upon the completion of a routine medical form. Although the examination must be complete and eventually recorded in an organized fashion, the data derived from a skillfully conducted interview are seldom obtained in the final written form. Indeed, any attempt to adhere rigidly to a specific outline will often impair the initial relationship between examiner

and patient to such a degree as to obviate the very purpose of the psychological examination.

For this reason we follow with interest rather than with approval recent developments in constructing a uniform psychiatric examination in which each patient is asked exactly the same questions and presumably in the same manner even by different examiners Such uniform interviews may have value for certain types of research, but they seem to us likely to interfere too much with the spontaneous demonstrations of interest and warmth (to the right amount!) that the psychiatrist should provide both to help the patient and to facilitate communication. In a different class, however, are check lists that the psychiatrist can fill out immediately *after* the examination. These do not interfere with the flow of the interview or examination, and they are most helpful in reducing important omissions in the examination.

The Importance of Nonverbal Behavior

We wish to emphasize also that the words of the patient often form a relatively small portion of all the data used in evaluating the mental state. Observations of other forms of communication, such as posture, gestures, facial expressions, or other signs of emotions and thoughts, can, in many instances, provide even more significant information than the patient's overt verbalizations. The long-suffering hypochondriac's secret twinkle of

enjoyment as she describes the effects of her many illnesses upon her family may supply an invaluable clue about the pathogenesis and meaning of her neurosis. The heavy-lidded, lusterless eye of the depressive frequently bespeaks more sorrow than his words could hope to encompass. The skillful examiner, like the good pediatrician, is exceptionally sensitive to that vast sphere of human interaction known as nonverbal communication. As in all forms of communication, however, specific components may be misleading, especially where their function is that of defense, denial, or masking. The smiling depressive who is secretly planning the “perfect" suicide may illustrate the latter all too tragically.

The Importance of Asking the Patient about His Condition

In our zeal to observe the patient we can sometimes forget that he has the best opportunity of anyone to observe himself. We should try to enlist him as a collaborative observer. Certainly gaps and distortions will occur in his observations, as in ours, but if we omit to ask him directly what he has noticed, how he feels, and what he thinks, we lose some of the most valuable material we can obtain. The following questions may illustrate ways of inviting the patient’s opinion of his condition: “What do you think about your condition?" “What would you say about your mood?" “How do you think your mind works now compared to when you were well (or compared to a year ago) ?"

Special Points of Technique

Examining Emotions

Chapter 53 included a description of the signals whereby one person communicates emotions to another, which we will not repeat here. As mentioned above, the examiner should always invite the patient to describe his emotions directly. Defensive concealment of emotions may cause discrepancies between what the psychiatrist observes in other signs and what the patient himself reports. Sometimes the patient may not understand the psychiatrist's question. To the question, "How are your spirits?" the patient may reply, "Fine," not because he feels well, but because he does not understand what the word "spirits" means in this connection. Questions about emotions and moods may need to be asked in several different ways before the patient understands.

In making inquiries about depth of depression and suicidal intentions, it is well to begin with the thought content of the depressive mood and work gradually upward toward the possible suicidal thoughts. This gives the patient a chance to volunteer whatever he will about suicidal thoughts and may also produce less of a shock when the psychiatrist finally asks direct questions. The frequency and importance of suicide require us to ask questions bearing on it whenever its possibility arises, as it does in most depressed patients and in many others.

We suggest the following group of questions as one series that can move the inquiry gradually toward the subject of suicide:

"How low do you get when you are depressed?"

"What do you think about when you are depressed?"

"Do you ever think that life is not worth living?"

"Do you ever wish you could die?"

"Have you ever thought of killing yourself?"

"What did you think you would do?"

"What would happen after you died?"

"Why does that seem the only solution?"

In evaluating mood and suicidal intentions the patient's verbal comments in response to the above questions furnish only a part and sometimes a small part of all the relevant data. The patient's speech, his motor attitudes and movements, his appetite and sleep, and his other verbalizations, for example, of hypochondriacal ideas or ideas of hopelessness, all constitute important information for the evaluation of his mood.

Examining Central Processes

Examining Memory.

Skillful guidance of the interview will often permit an accurate evaluation of both recent and remote memory. When it does not, more direct inquiries and examinations are indicated. These can begin with a question such as, “Have you had any trouble with your memory?" This gives the patient a chance to furnish further information. The psychiatrist may then continue with, “Do you mind if I ask you some questions to see just how good your memory is?" The patient assenting, specific questions that test the patient’s remote and recent memory can be employed. For example, in testing remote memory the patient may be asked the years of his birth, of his graduation from school, of his marriage, and of the births of his children. The psychiatrist may then wish to refine his examination by inquiring about items less likely to be well remembered, that is, less important events in the patient’s life, such as the year of a change of job, or events in the nation’s history through which the patient has lived.

Recent memory can be tested by questions pointed toward current situations or events just past. For example, the patient may be asked what he did the day before, where he lives, what he ate for breakfast, or who has visited him. If the examiner thinks the patient’s memory markedly impaired, he may ask the patient to tell him his (the physician’s) name. Assuming they were introduced at the beginning of the interview, this may test the patient’s memory over a period of half an hour or more. Additional tests of recent

memory can be accomplished by (1) showing the patient some objects, for example, a key, comb, coin, and watch, and asking him half an hour later to say what these were; (2) telling the patient a simple story and asking him to repeat it with all remembered detail; or (3) speaking a series of random digits to the patient and asking him to repeat them forward and backward. A healthy person of average memory should be able to repeat accurately a series of eight to nine digits forward and six to seven digits backward.

Recognition nearly always exceeds recall in disorders of memory. Consequently in examining memory the physician may first test the patient's recall for a given item and then, if he fails, offer it to him in a series of other items. For example, the physician can first ask a patient who has visited him. If the patient says he thinks someone visited but he cannot remember whom, the physician can next inquire: "Was it your wife, sister, brother, aunt, cousin?" With such assistance from the physician the patient may remember the correct name.

Examining Thought Processes.

Much of the data concerning the patient's thought processes will emerge during the history-taking interview as the psychiatrist observes the patient's behavior and studies his responses to specific questions. Notwithstanding these ample sources of information, the psychiatrist should

often ask the patient himself what he thinks about his thought processes. Suitable questions might include the following: “Does your mind work well, or as well now as it ever has?" “Do you have any difficulty in controlling your thoughts?" “Can you concentrate your thoughts now?"

Where doubt remains after the above observations or where diagnosis requires a more refined understanding of thought processes, the psychiatrist should proceed to more detailed testing. Sometimes he can accomplish this with a few simple questions, but sometimes he will need more elaborate tests administered by himself or a clinical psychologist.

The ability to manipulate mathematical symbols may be tested by asking the patient simple arithmetical problems such as: “Do you remember what 12 times 12 is?" or “Would you subtract 8 from 56 for me?" The subtraction of 7 from 100 serially provides an excellent test of calculation. Upon completing this exercise the patient may be asked to divide 7 into 100 with a view to noting whether the result agrees with that of the test of subtraction and, if not, whether the patient notices this discrepancy. Thus one test measures attention, the speed of thought processes, and the ability to detect errors and correct them. Moreover, when the test is timed one patient’s performance can be compared with that of another and also with his own performance on later occasions.

Sometimes calculations can be tested by asking the patient questions about his personal life that require him to calculate. For example, the psychiatrist may ask the patient naturally enough during the history-taking for the dates of various important events, such as the patient's marriage or the birth of his first child. Later in the interview he can ask the patient how old he was at the time of these events. This method has special value because it can be applied without the patient's being aware of any testing, which can hardly be the case when he is asked to subtract 7 from 100 serially. The subtler method can be used first, the more open method later if the first suggests a need for further examination of this mental function.

The psychiatrist will usually have had occasion during the earlier parts of the interview to evaluate the patient's ability for conceptual thinking. He should note whether the patient can form and express concepts clearly. When important impairments in concept formation are suspected, this capacity can be examined more definitively by testing the patient's ability to abstract.

Abstraction may be tested by asking the patient to compare and state the differences or similarities between different paired objects. Pairs commonly used are an orange and an apple, a tree and a fly, a dwarf and a child, a man and a dog, a lie and a mistake, a church and a theater. In offering such objects to test abstraction, the psychiatrist must know that the patient is familiar with them. Otherwise he may test only the patient's range of

information. The patient may also be given a series of words such as *high, cold, dark, near,* and so forth, and asked to supply their opposites or their synonyms.

The ability to generalize may be evaluated by asking the patient to give the meaning of well-known proverbs, such as: “The proof of the pudding is in the eating" or “A rolling stone gathers no moss." To these proverbs the patient may reply with several different types of abnormal responses. In a correct response the patient should interpret the proverb as a generalization of human experience. A patient with a disorder of thinking may fail to make the transition from the concrete example of the proverb to its general application to human behavior. Sometimes the patient may “explain" the first proverb by another proverb without interpreting the first proverb, or he may become engrossed in thinking about and discussing the images of the proverb. Thus to the proverb, “A new broom sweeps clean," a patient may reply, “Well, that’s right, when you get a new broom it will sweep cleaner." The patient may also see personal references in the proverb. For example, to the proverb, “It never rains but it pours," he may reply, “That’s the way it is with me. Every time I go out in the rain it pours." The intelligence of the patient must always be considered in evaluating the response to such proverbs. A person of low intelligence or poor education, however, usually gives no answer at all to the proverb, whereas a schizophrenic patient is more apt to supply a concrete answer, one with personal reference, or one with bizarre associations mixed

in.

Examining Thought Content.

The psychiatrist should probe the patients' thought content indirectly, encouraging him to talk freely and to disclose his important thoughts without being questioned specifically. Should this maneuver fail, the examiner should not hesitate to ask direct questions about the patient's central preoccupying thoughts. He can say, for example, "Can you give me an idea of the main things you think about?" "What do you think about most?" "What sort of thoughts come into your mind?" "Do you have any thoughts that keep coming back to you?" "Do you have any thoughts you can't get rid of?" "Do you have any special daydreams or fantasies?"

Many patients do not understand the word "fantasy" and may even be unfamiliar with the expression "daydream"; therefore, the psychiatrist may find it helpful to ask the patient such questions as: "What things do you imagine yourself doing in the future?" "What would you ask for if you could have three wishes granted?" "Do you often imagine how you would like things to be in the future?"

If the patient has not exposed his thoughts freely in the course of the history-taking interviews, he may not do so any more readily in response to the direct questions suggested above; the latter certainly do not guarantee a

frank answer. On the contrary, direct questions may merely intensify defensiveness. When the psychiatrist does ask direct questions, he will have to judge each time to what extent the patient has been able to expose his thoughts. The detailed examination of irrational ideas and delusions requires simply an extension of the principles already outlined. The psychiatrist must gradually evoke the patient's trust so that he can confide without fear. In doing so he must often travel the narrow path between endorsement of the patient's delusions and rejection of them as totally preposterous or "imaginary."

Note should be taken of the ease with which the patient talks about his irrational ideas or delusions. When a patient holds his beliefs critically and still tries to test them, he may be unwilling to confide them in a physician. One does not ordinarily communicate an unusual idea to another person unless he either believes strongly in its truth or feels assured of the other person's acceptance of him. Therefore, delusions that carry strong conviction are usually readily revealed. On the other hand, skillful inquiry may be needed to discover maturing but unripe delusions. Material suspected of delusional elaboration must be approached tactfully and with an assumption of the reasonableness of the patient. If a critical, challenging attitude is adopted, the patient may avoid the subject altogether or at least conceal the existence of any idea, such as an incipient delusion, that he thinks the psychiatrist may doubt.

Some psychiatrists avoid all interrogation of psychotic patients about delusions or hallucinations on the ground that such questions can harmfully crystallize ideas that the patient still holds in solution, as it were. We have already advocated an examination in which the patient is guided to deliver the necessary data in a conversational way, with as much avoidance as possible of direct questions. However, sometimes questions are helpful and essential to the clarification of the patient's symptoms. We believe the manner of questioning is much more important than the questions themselves in promoting the patient's delusions or otherwise injuring him. And certainly the psychiatrist should carefully avoid any suggestion of forcing the patient to talk of what he wants to keep to himself.

When the patient does confide delusional material to the psychiatrist, the latter should also ascertain to what extent he has revealed his thoughts to other people. The psychiatrist should know whether the patient considers the psychiatrist a special person and whether he has delusional ideas about the psychiatrist. Failure to note the latter may seriously impair the validity of the entire examination.

Patients often spontaneously verbalize expressions of apparent insight that have little relevance to a sound understanding or little application in their subsequent behavior. Consequently it is often helpful and necessary to ask direct questions focusing more sharply on insight. However, as with

responses to other direct questions, the patient's answers will take their place with other data that may prove more important in evaluating insight. The physician may ask such questions as: "How do you think you became ill?" "What do you think is the matter?" "What brought all this on?" "What do you think are the causes of your illness?"

Examining Perceptions

Examining Illusions and Hallucinations.

When inquiring about illusions and hallucinations, the examiner should start with questions about experiences resembling those anyone can have. Because illusions and hallucinations are unusual experiences, the patient may have difficulty in recognizing what he has experienced or in describing it in everyday language. He may need to be offered a variety of questions before he understands what is being asked.

The following examples of introductory questions may prove useful:

Have you ever bad something like a dream when you thought you were awake?

Have you ever had anything you might call a vision or seen an apparition?

Have you ever thought you heard people talking when no one

was around?

Do you ever seem to confuse your thoughts and someone else's thoughts, as if someone might be putting things into your mind or even saying things to you?

When the patient answers such questions affirmatively, or when his behavior clearly indicates that he is hallucinating at the time of the examination, the psychiatrist should push the inquiry with further questions designed to learn as much as possible about such experiences. He can ask, for example: "What do you see (hear)?" "Who seems to be doing this (saying these things)?" "What is happening?" "Why are they doing this?"

The patient's complaints will usually include depersonalization and estrangement when these have occurred importantly in the illness. However, when he does not volunteer information about these symptoms that the psychiatrist nevertheless suspects from other data, they should be inquired about directly. One may ask, for example: "Have you ever felt as if you were not yourself, or as if you had changed so you couldn't recognize yourself?" "Did you ever think that everything around you seemed different or strange or unfamiliar?"

Examining Attention, Concentration, and Clarity of Consciousness.

Important defects of concentration will usually appear in the interviews

without special testing. However, it may be desirable to test the patient's ability to hold his attention on some task, and this can be done by asking him to subtract 7 serially from 100. If the patient cannot subtract he may be asked to repeat groups of digits of increasing length. Ability to subtract serial 7's from 100 provides a useful and semiquantitative index for comparing changes in the patient's condition from day to day as a delirium clears or becomes worse. Performance can be timed and notes made of errors, of whether the patient notices his mistakes and tries to correct them, and of any wandering of his attention from the task. If this test is used often, the patient's speed may improve through learning. Varying the test by asking the patient to start at 101 or 102 can reduce whatever distortion this might bring.

Examining Orientation.

Much can be learned about the patient's orientation simply by careful attention to his remarks during the interview. If these do not provide adequate data, the physician should always turn toward more direct questions. Orientation may therefore be evaluated in several different ways:

1. Inferences made from listening to the patient's spontaneous references to people, places, and events during the earlier parts of the interview.

2. Questions designed to test orientation, but not asking directly about this. The patient may be asked where he was before

coming to the office (or hospital), and whether he had difficulty finding the office. His reply may reveal whether he is oriented for place. Simple inquiries about recent events demonstrate whether he is oriented for time. Other questions may similarly test orientation for situation and person.

3. Direct questions about orientation. The psychiatrist should use these only after he has tried the other approaches, unless the patient seems obviously disoriented; in such cases he may proceed immediately to direct questioning. However, he should not hesitate to use direct questions when any doubt remains after use of the indirect approaches mentioned above.

The psychiatrist should usually begin with inquiries that suggest less extreme disorders and proceed from these to test for complete disorientation. For example, a first level of inquiry might include the following questions:

> Do you keep track of time fairly well? Do you know what day (date, month, year) it is?
>
> Where do you live? How do you get there from here?
>
> Why did you come here?

A second and potentially more shocking level of questions might include the following:

Do you know where you are now? What place is this?

Do you know who I am? What is your name?

What time of day is it now?

A partially delirious patient may be disoriented without knowing this. Questions such as the above may alarm him by exposing the severity of his condition. This additional anxiety may actually increase his confusion. After such questions the psychiatrist should therefore always offer some appropriate reassurance. And if the patient is not oriented, the psychiatrist should attempt to furnish orientation to the patient. He should say who he (the psychiatrist) is, where the patient is, briefly why he is where he is, and what he may expect next, together with any other information that he thinks the patient can usefully assimilate in his condition.

Concluding the Examination

Even an initial or diagnostic interview must have some discernible value to the patient. The nuclear components of all therapy, the decrement of anxiety through a relationship of basic trust and the increment of self-esteem, are just as vital to the initial interview as they are to long-term treatment.

No matter how limited his remarks, the examiner should express, by word or gesture, some understanding of the patient's problems and his

appreciation for his cooperation during the interview. If at all possible he should conclude the interview with some clarifying statement about the patient's immediate future. If the examination has been skillfully conducted, the opportunity for ventilation in an uncritical, nonjudgmental setting may be quite anxiety relieving and integrative in itself. Every effort should be made to increase the patient's sense of wholeness and dignity in an often insecure and troubled world. Trite generalities and superficial platitudes are often more alienating than therapeutic. Clarification and reassurance, medicine's most common aids, must always be realistic and based on an accurate, sincere evaluation of the facts, including those that the patient may well have overlooked. Good medical practice requires the active participation and intelligent cooperation of the patient; communicating and enlisting the latter are primarily responsibilities of the skilled examiner.

Appendix: Examination of Inaccessible Patients

Many psychiatric patients are inaccessible for effective verbal communication. This occurs when patients are mute (for example, in catatonia and severe depression), excessively garrulous (for example, in manic psychoses and some senile psychoses), or excited (for example, in schizophrenic excitements). The inaccessibility of different patients of this group varies greatly, and it also varies in the same patient from time to time. Indeed, few patients are totally verbally uncommunicative. The psychiatrist

should try to discover under what circumstances the patient becomes communicative with him or with others. Certain persons or certain remarks of the psychiatrist himself may open up the patient's verbal communications. These successful stimuli should be carefully noted in order to utilize them in further developing contact with the patient.

While waiting for the availability of such stimuli, the psychiatrist may still learn much from observing a patient who does not talk usefully or talk at all. Such a patient may signal much about himself with the movements of his face and body or with his gestures or other behavior. A sudden grimace, a single glance, or a series of body movements may reveal more than a thousand words.

Facial Expression

Both the habitual expression of the face and changes in expression should be noted. The hangdog face of the depressive and the fatuous grin of the hebephrenic communicate immediately to the observant. The eyes especially deserve attention. The poets have referred to the eyes as "the doorway to the soul." In a more mundane but practical sense an awareness of ocular expression can be of immense assistance to the astute clinician. Patients whose life experiences have conditioned them to distrust verbal communication, for example, certain schizophrenic patients, may be quite

sensitive and adept in this sphere.

Bodily Activity

Posture, gait, and other motor activity may be informative. The despairing slouch of the depressive and the proud, defensive posture of the paranoid vividly communicate important attitudes. The patient may employ such communicative signals as grunts, grimaces, or gestures with his hands. Motor expressions of hostility and anger often tell much about the thoughts of a mute patient. A seemingly disinterested catatonic may revealingly clench his fist or shift his position when his defensive isolation is challenged too aggressively. Seductive posturing and unconscious gestures may portray attitudes that could not otherwise be communicated.

Response to Stimulation

The patient's responses to environmental changes, verbal greetings, or direct physical stimulation should be noted and recorded. The examiner may also observe the patient's reactions when personal topics relative to his home or family are discussed within his hearing. Will he cooperate with such routine requests as suggestions that he open his eyes or change his position? Does he disregard noxious stimuli such as glaring sunlight or an obviously uncomfortable posture? Does he let his cigarette burn his hand? Many mute

and seemingly unresponsive schizophrenic patients can be brought into activity by throwing them a ball and engaging in direct motor activity with them. Such stimulation apparently causes them to leave their inner world temporarily and enter into contact with others.

Other Behavior

The spontaneous behavior of the patient should be noted, especially with respect to his responses to persons who approach him. What does he do when he is left alone? Does he make any effort to communicate his needs? Does he accept cigarettes or food when offered? Is he incontinent? Does he feed himself? Does he preserve some concern for his appearance or neglect this altogether? The psychiatrist might note, for example, whether a mute female patient continues to comb her hair or use lipstick; such behavior usually indicates a degree of self-esteem and some continuing interest in others.

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