

PSYCHIATRIC HISTORY TAKING

&

MENTAL STATE EXAMINATION



DEPARTMENT OF PSYCHIATRY

PGIMER, CHANDIGARH

PSYCHIATRIC HISTORY TAKING

History taking and the mental state examination are core clinical skills. Unlike other medical specialties, the uniqueness of psychiatry is that most of the diagnostic information comes from the history and observation of the patients' appearance, behavior and mental state examination.

History taking in psychiatry is a skill and is best learned by supervised practice, corrective feedback, by observing others and by repetition. For enhancing one's skills one needs to see and interview as many patients as possible in the initial formative years of residency. A good history taking requires a good knowledge of the subject, knowledge about the culture to which the patient belongs and understanding of the dialect of the patient.

Few basic things are essential to know before starting psychiatric history taking:

- The interview should be focused so as to establish a criteria based diagnosis
- The interview room should be relatively sound proof
- Consent must be obtained from patient and the attendants/family members before starting the interview
- Privacy and confidentiality of information should be ensured and the therapist must respect the patient's needs, must be empathetic and try to establish a good rapport with the patient.
- One should use more open ended questions and try to avoid closed ended or compound questions and should refrain from giving premature advice.
- The interview must end with giving the patient an opportunity to ask questions.

History taking should be taken in a proper format as mentioned below.

1. **Personal data/ identification data:** It typically includes the patient's name, age, gender, educational, occupational and marital status (or significant other relationship), race or ethnicity, socio-economic status and area of residence. Often the referral source is also included. Having a good understanding of these variables can at times influence the treatment decisions. For example, which psychotropics to prescribe to a poor patient, which medications must not be prescribed to a young woman/elderly, how frequently can the patient be called for follow up (distance issues).

2. **Informants:** The name, relationship to the patient and how long is the informant staying with the patient since the onset of illness should be mentioned. The hierarchy of informants can be as per the informant who had provided the most information and who had stayed with the patient for long duration.
3. **Nature of information:** Particular emphasis should be given to the nature of information available from the patient and informant. It is important to clarify where the information has come from, especially if others have provided information and/or records reviewed, and the interviewer's assessment of how reliable the data is. It should be mentioned how much reliable and adequate the information is.
 - **Reliability-** When the given information is consistent amongst different informants and over different period of time.
 - **Adequacy-** if with available information, a differential diagnosis can be entertained and a management plan can be made, then the information can be said to be adequate.
4. **Chief complaints:** The main complaints in patient's language in brief with their duration in chronological order in the same format for all complaints. The nature of chief complaints should be written in a way that they have some diagnostic indicator. It should be separately listed for both patient's and caregivers. This should be the patient's complaint, ideally in their own words. Examples include, "*I'm sad,*" or, "*Neighbors are trying to harm me*". Presenting complaints are the complaints/ the reasons for the present visit of the patient and caregivers. These can be same as the chief complaints or represent a subset of chief complaints. For example, for a depressed patient, the presenting complaint could be "*refusal to eat*", which actually led to current consultation/admission.
5. **Onset-** The time period between appearance of first symptom to full blown abnormal symptoms/syndrome of a diagnosable disorder (Abrupt- 48hrs; Acute- 2 weeks; Sub acute- 2 weeks to 1-2 months; Insidious- > 1-2 months)
6. **Course-** Description of the manner and speed of evolution and progression of the disorder (**Continuous:** fluctuating, stable, progressive, periodic exacerbation; **Episodic-** with complete or incomplete inter episodic recovery, improving)

7. Predisposing, precipitating factor, perpetuating factor :

- Predisposing factors -Those risk factors which act for a longer period of time or during an earlier part of life, makes an individual vulnerable to develop an illness.
- Precipitating factor- Those risk factors which operate immediately before the onset of illness (i.e. have temporal co-relation with the onset of illness) and in the absence of which the illness might not have occurred)
- Perpetuating/maintaining factor- which maintain or aggravate the illness.

8. History of presenting illness :A description of the symptoms and their duration which should include (try to explain every symptom by ABC – Affect- Behavior - Cognition)

- a. How the symptoms began, and how the symptoms changed with time (gradual progression/episodic/remained the same) : Exact chronology of events/time frame
- b. Evolution of symptoms (factors which increase/decrease the symptoms), course of symptoms, relationship of symptoms with each other, relationship of symptoms with life changes, help seeking, relationship with personality, relationship of symptoms with treatment, stress)
- c. Changes in the biological functions (sleep/appetite/weight) should also include any other changes that have occurred during this same time period in the patient's interests, interpersonal relationships, behaviors, personal habits, physical health, biofunctions and the extent of socio-occupational dysfunction.
- d. Association between symptoms and any stressors/life events- The presence or absence of stressors should be established, and these may include situations at home, work, school, legal issues, medical comorbidities, and interpersonal difficulties and effort to be made to find any association between symptoms and stressors.
- e. How was the predominant mood/ affect along with extensive elaboration of phenomenology of psychotic/mood symptoms.
- f. Effect of the symptoms on patient's relationships, day to day activities and work/occupation, social functioning etc.
- g. Factors that alleviate or exacerbate symptoms (medications, support, coping skills, or time of day)

- h. All the symptoms and their severity with duration along with associated factors should be mentioned
- i. All associated signs or symptoms must be explored to confirm syndromic presentation
- j. Extensive elaboration of cognitive functions
- k. Specific enquiry of suicidality and detail elaboration of any self-harm attempt
- l. Co-morbid physical illness and substance abuse history in brief and any relationship of the psychiatric history with the same should try to be explored.
- m. Treatment received so far from all sources (medical and non-medical) with degree of improvement and side-effects. It is also important to identify why the patient is seeking help now. If any treatment has been received for the current episode, it should be defined in terms of what was done (e.g., psychotherapy or medication), and the specifics of the modality used (e.g., doses of medication), adequacy of the treatment and the effect of these interventions.
- n. **Basic tips :**
 - i. Divide history into small parts
 - ii. If describing a small history- may give details of each day
 - iii. If describing a long history- give information about a typical day
 - iv. How the symptoms were carried forward
 - v. Description of symptoms rather than diagnostic label
 - vi. Each symptom should be described in such a way that it reflects completeness of description, shows that all possible phenomenon have been considered with a possible impression of the therapist/doctor
 - vii. Describe one symptom at one go, intensity of symptoms
 - viii. Judiciously use negative history in the HOPI, while considering to show that you have considered various differential diagnosis
 - ix. Always remember to consider organicity and substance use as differentials
 - x. Negative history: symptoms that were not present during the course of the present illness starting with the negative history of the syndrome which is the possible diagnosis in the case followed by negative history for other

disorders, organicity and substance abuse. It is useful in differential diagnosis.

9. Past history :

- a. Co-morbid medical/surgical illness: The past medical history includes an account of major medical and surgical illnesses and conditions as well as treatments, both past and present. The patient's reaction to these illnesses and coping skills employed are important to understand. The past medical history is an important consideration when determining potential causes of mental illness as well as comorbid or confounding factors and may dictate potential treatment options or limitations. Medical illnesses can precipitate a psychiatric disorder (e.g., depression in an individual recently diagnosed with HIV), imitate a psychiatric disorder (hyperthyroidism resembling an anxiety disorder), be precipitated by a psychiatric disorder or its treatment (metabolic syndrome in a patient on a second-generation antipsychotic medication), or influence the choice of treatment of a psychiatric disorder (hepatic dysfunction disorder and the use of disulfiram). It is important to pay special attention to neurological issues including seizures, head injury and pain disorder. Non-psychotropic medications, over-the-counter medications, sleep aids, herbal, and alternative medications should also be reviewed. These can all potentially have psychiatric implications including side effects or producing symptoms as well as potential medication interactions. Duration of each illness with treatment taken/not taken; any accident/injury
- b. Psychiatric history: All information about all psychiatric illnesses and their course over the patient's lifetime, including symptoms and treatment. Because comorbidity is the rule rather than the exception, in addition to prior episodes of the same illness (e.g., past episodes of depression in an individual who has a major depressive disorder) the therapist should also be alert for the signs and symptoms of other psychiatric disorders.
 - i. Description of past symptoms should include when they occurred, how long they lasted, and the frequency and severity of episodes. Elaborate the information of previous similar/dissimilar episode with its psychosocial

background, impairment caused to patient along with treatment received/manner by which the symptoms resolved

- ii. Past treatment should also be reviewed in detail. These include outpatient treatment such as psychotherapy (individual, group, couple, or family), inpatient treatment, including voluntary or involuntary and what precipitated the need for the higher level of care, support groups, or other forms of treatment such as vocational training. Medications and other modalities such as electroconvulsive therapy or alternative treatments should be carefully reviewed. One should explore what was tried, how long and at what doses were used (to establish adequacy of the trials), and why these were stopped. Important questions must include what was the response to the medication/modality and whether there were any side effects. It is also helpful to establish whether there was reasonable compliance with the recommended treatment.
- iii. Specific enquiry into completeness of recovery and socialization/personal care in the interim period.
- iv. Past suicidal ideation, intent, plan, and attempts; violence and homicidal behavior: Special consideration should be given to establishing a lethality history that is important in the assessment of current risk. Past suicidal ideation, intent, plan, and attempts should be reviewed including the nature of attempts, perceived lethality of the attempts or other death preparations. Because many patients will withhold specific information about recent suicidal behaviors or suicidal ideation, several specific behavioral questions may be used to determine how close the patient was to a lethal attempt. Violence and homicidality history should include any violent actions or intent. History of non-suicidal self-injurious behavior should also be recorded.

10. Family history and family history of mental illness: Many psychiatric illnesses are familial or family environment may have a pathogenic role hence, a careful review of family history is an essential part of the psychiatric assessment. An accurate family history helps not only in defining a patient's potential risk factors for specific illnesses but

also the formative psychosocial background of the patient. Psychiatric diagnoses, medications, hospitalizations, substance use disorders and lethality history should all be covered. The importance of these issues is highlighted, for example, by the evidence that, at times, there appears to be a familial response to medications and a family history of suicide is a significant risk factor for suicidal behaviors in the patient. Proper understanding of medical illnesses present in family members may also be important in both the diagnosis and the treatment of the patient. Family traditions, beliefs, and expectations may also play a significant role in the development, expression, or course of the illness. Also the family history is important in identifying potential support as well as stresses for the patient. It should be recorded as :

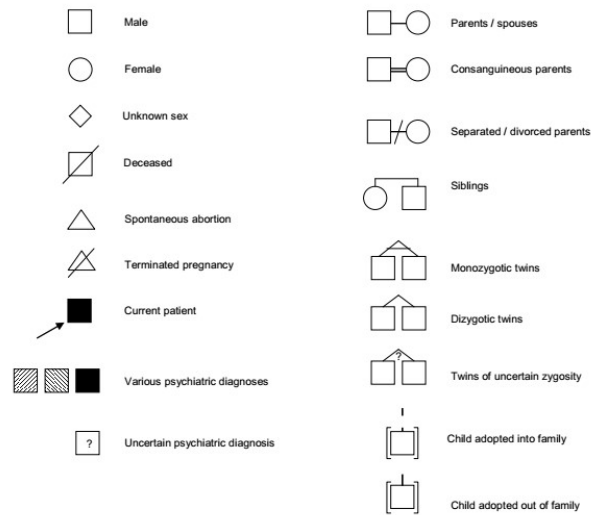
Father: (Age, education, occupation, general personality and relationship with patient; if deceased: age at, date and cause of death) –

Mother: (Age, education, occupation, general personality and relationship with patient; if deceased: age at, date and cause of death) –

Siblings: Age, Sex, education, occupation, marital status.

Use of pedigree chart/genogram with proper symbols is a must while writing family history (as shown in figure below) .Family history of mental illness: including mental retardation, epilepsy, alcohol and/or drug dependence, suicide, renouncing world etc. in grandparents, uncles, aunts, first cousin, siblings and children.

Figure 1: a list of symbols used in genograms



11. **Personal history:** The personal history reviews the stages of the patient's life. It is an important tool in determining the context of psychiatric symptoms and illnesses and may, in fact, identify some of the major factors in the evolution of the disorder. Frequently, current psychosocial stressors will be revealed in the course of obtaining a social history. It can often be helpful to review the social history chronologically to ensure all information is covered. It should include :

- Date and place of birth, Home or hospital delivery, any childhood illness
- Bowel and bladder habits: History of Constipation
- Food habits: Veg/Non-Veg
- Sleep habits: Sleeping time and waking time prior to onset of illness including any change over the years

12. **Developmental history:** Any available information concerning prenatal or birth history and developmental milestones should be noted. For the large majority of adult patients such information is not readily available and when it is, it may not be fully accurate. Any known history of prenatal or birth problems or issues with developmental milestones should be noted. Childhood history should include childhood home environment including members of the family and social environment including the number and quality of friendships. Childhood physical and sexual abuse should be carefully queried.

- a. Antenatal and birth history

- b. Early developmental history
 - c. General health in childhood
 - d. Any neurotic traits
13. **Educational History:** A detailed school history including how far the patient went in school and how old were at that level, any special education circumstances or learning disorders, behavioral problems at school, academic performance, and extracurricular activities should be obtained. Highest level of educational attainment along with educational problems if any; peer relationships
14. **Occupational history:** Jobs held in chronological order, give dates, adjustment with peers and superiors, specific difficulties, promotions, reasons for change of jobs, age of retirement/ moving away from active work. The nature of the patient's relationships with supervisors and co-workers should be reviewed. The patient's income, financial issues, and insurance coverage including pharmacy benefits are often important issues.
15. **Sexual and marital history:** Marriage and relationship history including sexual preferences, gender identity and current family structure should be explored. This should include the patient's capacity to develop and maintain stable and mutually satisfying relationships as well as issues of intimacy and sexual behaviors. Current relationships with parents, grandparents, children, and grandchildren are an important part of the social history.
- a. Age at menarche and menopause, reaction to it and menstrual cycles, sex education, masturbation and associated guilt feelings, homosexual contacts, premarital and extramarital relationship.
 - b. Menopause related symptoms: Hot flushes, mood swings, intermitted spotting, post coital spotting
 - c. Marriage how arranged, date of marriage, age and occupation of the spouse, general adjustment, ages and gender of children.
 - d. Sexual adjustment and sexual problems in the past and currently sexually active or not
 - e. IPR issues if any.

16. **Religion:** Religiosity, level of participation, any sudden changes in religion/religious participation etc. It is important to identify cultural and religious influences on the patient's life and current religious beliefs and practices.
17. **Present living situation:** The residence, who all live with the patient, sharing of income, expenses, kitchen, domestic conflicts, overall social class. In case of married women details of the members in the in-law family.
18. **Premorbid personality:** The premorbid personality of the patient often gives valuable insights into his/her symptomatology, diagnosis and management. Ideally, the premorbid personality of an individual should be assessed in the interview with corroborative evidence. Patients who are unwell often give a false reporting of their premorbid personality, and in cases where there is no available informant, a reassessment may be warranted once patient's symptoms have improved. **It should include social relations, intellectual activities and hobbies, mood, character, attitude towards work and responsibility, interpersonal relationships, energy, habits and fantasy life.** Personality traits like passive vs. active, assertive vs. submissive, introvert vs. extrovert, loner vs. sociable, anxious and worrisome, compulsive, suspicious should be asked for. Specific habits (eating, sleep and excretory) and hobbies, interests should also be documented.
19. **Substance abuse history:** A careful review of substance use, abuse, and addictions is essential to the psychiatric interview. The clinician should keep in mind that this information may be difficult for the patient to discuss, and a nonjudgmental style will elicit more accurate information. If the patient seems reluctant to share such information specific questions may be helpful (e.g., *"Have you ever used intravenous drugs?"* or *"Do you drink alcohol every day?"*). History of use should include what substances have been used including alcohol, drugs, medications (prescribed or not prescribed to the patient), and routes of use (oral or intravenous). The frequency and amount of use should be determined keeping in mind the tendency for patients to minimize or deny use that may be perceived as socially unacceptable. Other important substances and addictions that should be covered in this section include tobacco and caffeine use. Use of substances in exact pattern as reported by patient and informants. Exact duration of use and periods of abstinence should be enquired and effort should be made to ascertain if the patient fulfills

the criteria of dependence (any aggravation of symptoms with increase in substance intake or vice-versa).

Physical examination

General:

- Appearance, body build and nutrition
- Pallor/Icterus/Edema/Cyanosis/Clubbing/Lymphadenopathy
- Malnutrition/Obese
- Any signs of nutritional deficiencies (Chelosis/ ulcers in mouth/loss of texture of skin/generalized wasting/fatigue/ Pica /brittle nails/ poor night vision/ restless legs/ burning feet sensation/ ataxia etc.)
- Osteoarthritis /Joint pains
- Hearing /Visual impairment
- Neuropathy
- Skin conditions : Diffuse hyperpigmentation/Pruritus/ Red scaly skin/Bruising etc
- Any evidence of thyroid swelling

Pulse:

B.P.:

Ht:

Wt:

Waist circumference:

Fundus

CVS: (Apex beat, regularity, heart sounds, murmurs)

Chest: (Expansion on the two sides, percussion, adventitious sounds)

Abdomen: (Tenderness, mass, bowel sounds)

CNS:

Cranial nerve Examination :

Cranial Nerve	Findings	Cranial Nerve	Findings
I		VII	
II		VIII	
III		IX	
IV		X	
V		XI	
VI		XII	

Motor system

Bulk	UL	LL
Tone	UL	LL
Power	UL	LL
Co-ordination		
Tendon reflexes	Superficial	Deep
	Abdominal -	Knee reflex-
	Plantar – Flexor/Extensor	Biceps reflex-
		Triceps reflex-
		Supinator reflex-

Sensory system

Fine touch	UL	LL
Crude touch	UL	LL
Vibration	UL	LL
Pain/Pressure	UL	LL
Proprioception	UL	LL
Stereognosis		

Cerebellar signs:

- Gait (shuffling/waddling/scissoring/ swinging) –Describe
- Balance - Ask the patient to walk heel-to-toe
- Romberg's Test –
- Resting tremors –
- Dysdiadochokinesis –
- Finger-to-nose test –
- Heel-to-shin test –

Any meningeal signs of irritation –Kernig's sign, Brudzinski's sign

Skull and Spine -

MENTAL STATE EXAMINATION (MSE)

Mental status examination in psychiatry is equivalent to physical examination of physical medicine. MSE gives idea of cross sectional /current state of mind or mental state of a person. It has to be done in a standardized format and it provides a lucid account of the observation made by the examiner. It also accounts for the recording and documentation of all the psychiatric signs and symptoms present at the time of interview.

It is covered under following headings:

- 1. General Appearance, attitude and behaviour*
- 2. Psychomotor Activity*
- 3. Speech*
- 4. Mood*
- 5. Affect*
- 6. Form of thought*
- 7. Thought content*
- 8. Possession of thought*
- 9. Perceptual disturbances*
- 10. Cognitive functions*
- 11. Judgment*
- 12. Insight*

1. General appearance, attitude and behavior (GAAB)

General Appearance:

- **General health and Body built**

- Sick/weak/healthy/bedridden/wheelchair bound
- Does the patient appear older than his/her chronological age (prematurely aged), or younger (immature appearance)
- Lean/obese

- **Dressing and Personal cleanliness**

With regard to the looks of the patient, one should focus on key features like how is the patient groomed, is he tidy, is he well kempt, what is the facial expression of the patient, does the patient has any abnormal movements and is there something typical/ atypical about patient. *For example, just observing that a patient entered the interview situation with a thumping gait, is dressed in bright colour dress and is having various religious threads around the neck, can provide significant lead for further evaluations for conditions like mania or psychosis depending on other associated features.*

- Dressed appropriately/inappropriately/ neatly dressed/shabby : adequate, appropriate, any peculiarities
- Facies (non-verbal expression of mood visible on face)
- Any disfigurations, scars, and tattoos should be noted.
- Grooming (overly groomed/poorly groomed)
- Shaved/kempt/unkempt/untidy/bad odour: hygiene of the patient

- **Eye to eye contact**

- Initiated/maintained (>50 % of interview –normal) /not initiated or maintained/initiated but maintained for few minutes.Gaze aversion, staring vacantly, staring at the examiner, hesitant (shy) eye contact, or normal eye contact should be mentioned too.

- **Gait and posture:** Normal or abnormal (way of sitting, standing, walking, how patient is lying on bed), how the person sits/maintains his attire throughout the interview, whether patient is comfortable/ uncomfortable.Any unusual or sustained postures and pacing should be noted and described. The presence or absence of any tics should be noted, as should be jitteriness, tremor, apparent restlessness, lip-smacking, and tongue protrusions.

- **Attitude towards examiner:**Cooperation/guardedness/evasiveness/hostility/combativeness/haughtiness/attentiveness/appears interested/disinterested/apathetic/confused

- **Social manner and non-verbal behaviour :** With regard to patient's behaviour attention should be paid to facts like how much importance does the patient give to the social norms of greeting to each other, whether he waits till he is asked to sit, does he sit still or is he fidgety, does the patient make eye contact, is one able to emotionally connect with the patient, what is the affect of the patient, does the patient exhibit any odd behavior, does the patient appear to be interested in the interview, or appears angry and confrontative etc. Hallucinatory behaviour: smiling or crying

without reason, muttering or talking to self (non-social speech), odd gesturing in response to possibly auditory or visual hallucinations

- **Rapport :** It is a relationship of mutual understanding or trust and agreement between people. The harmonious responsiveness of the physician to the patient and the patient to the physician (CTP – IX). An instantaneous reciprocal emotional resonance between patient and interviewer. It might be established with the patient easily, with difficulty, with efforts or not established at all.

Example: GAAB

Patient entered the room alone, carried a water bottle in her hands, sat on chair offered and returned greetings of the therapist ; looked back to check if the door was closed. Was tidy and well kempt. Appeared to be anxious in the beginning of the interview and had to be persuaded several times to speak about her problems. Asked for reassurance 2- 3 times that if she can get well soon. Kept on shifting her posture on chair ; was fidgety and drank sips of water 2-3 times in between the interview. Eye to eye contact was initiated and maintained. Rapport could be established.

2. Psychomotor activity and Speech : Goal directed response involving both motor and psychological component. Motor activity may be described as normal, decreased (generalized slowing, bradykinesia), or increased (agitated, restless). This helps to understand the diagnoses (e.g., depression versus mania) as well as possible neurological or medical issues. Paying attention to psychomotor activity can also provide clues to adverse reactions or side effects of medications such as tardive dyskinesia, akathasia, or parkinsonian features. It is reported as:

- Normal/average
- Increased
 - Agitation: severe anxiety associated with motor restlessness
 - Over-activity : abnormality in motor behavior that can manifest itself as psychomotor agitation , hyperactivity , tics etc
 - Excited : agitated, purposeless motor activity uninfluenced by motor stimuli
- Decreased
 - Abnormal physical and/or psychological slowing as a part of any illness
 - Any stupor, akinesia (not able to move) and mutism (unable to speak)

3. Speech: A conditioned motor reflex which is the articulation and phonation of language and sounds. While describing the speech, one should consider the fluency, amount, rate, tone, and volume of the spoken speech.

- **Fluency** refers to whether the patient has full command of the language as well as to potentially more subtle fluency issues such as stuttering, word finding difficulties, or paraphasic errors.
- Along with this, it is important to assess the **rate of the speech**. Is it slowed or rapid (pressured)?
- The evaluation of the **amount of speech** refers to whether it is normal, increased, or decreased. Decreased amount of speech may suggest anxiety or disinterest, thought blocking or psychosis. An increased amount of speech is frequently seen in mania or in agitated psychotics.
- The **volume** of spoken speech is also frequently increased in mania or agitated patients and decreased in depressed or anxious patients.
- **Tonal inflections** are exaggerated in demonstrative patients and may be decreased in patients with psychosis.

Speech can be examined under the following headings:

- Relevance : answering precisely (Relevant /irrelevant)
- Coherence : understandability (Coherent/incoherent)
- Spontaneous (on his own) / in response to question
- Rate/Tempo – speed (>150 words/min – pressure of speech)
- Amount – increased/decreased/average
- Volume – amount the patient speaks on a particular subject; loudness (soft whispering to loud speech)
- Tone – pitch and loudness
- Tonal inflections – present/absent
- Reaction time : time taken to respond (average/ prolonged / reduced)

Points to note: While interpreting any of the above features, patients own premorbid level should be considered as the comparator, *rather than the therapists own speech or features of speech noted in general.*

4. Mood and Affect

- **Feeling** : A positive or negative reaction to some experience / event ; the subjective experience of emotion
- **Emotion**: A stirred-up state caused by physiological changes occurring as a response to an event and which tends to maintain or abolish the causative event.
- **Mood**: Mood is defined as the person's internal and sustained emotional state. Its experience is subjective, and hence it is best to use the patient's own words in describing their mood. Terms such as "sad," "angry," "guilty," or "anxious" are common descriptions of mood. *It is the sustained/constant emotional feeling tone which is experienced internally (lasts for some length of time) and affects person's behaviour and perception of the outside world.*
- **Affect**: Affect represents the patient's current state of emotional responsiveness. It should be assessed by observing the outward display of emotion by the patient. Affect is often described with the following elements: Quality, range, reactivity and appropriateness. Terms used to describe the quality of a patient's affect include dysphoric, happy, euthymic, irritable, angry, agitated, tearful, sobbing, and flat. It is described as:
 - Subjective : *What the patient says when asked about how is his mood.*
 - Objective : *What appeared to the examiner during the interview*
- *As per Fish's psychopathology : Affect is a sudden exacerbation of emotion, and mood is the emotional state prevailing at any given time, in other words, both mood and affect are short-term emotional tone*
- *As per Sims' : 'Affect is momentary, while mood is prolonged emotion'*
- *As per DSM-IV TR :Mood refers to a more pervasive and sustained emotional 'climate', whereas, Affect refers to more fluctuating changes in the emotional 'weather'.*
- Mood and affect are assessed subjectively as well as objectively by looking at face and described as general warmth, euphoria, elation, exaltation and/or ecstasy in mania; anxious and restless in anxiety and depression; sad, irritable, angry and/or despaired in depression; and shallow, blunted, indifferent, restricted [narrow in range], inappropriate. Anhedonia may occur in both schizophrenia and depression.

- Range of affect : Represents the entire continuum of affective states seen during the interview. It may be described as “restricted” or “blunt”, indicating pathological state.
- The reactivity of the affect: Indicates the change in the affect in relation to environmental or internal stimuli (e.g. if the patient smiles when the therapist makes a light hearted comment). It should also be noted if the affect of the patient is appropriate to the current circumstances, clinical situation and what he/she is thinking about (thought content).
- **Affect description in MSE:**
 1. Subjective
 2. Objective – depressed, euphoric, elated, blunted, flat
 3. Range : wide, restricted (over a course of time) (happy, sad, angry, placid, fearful)
 4. Reactivity: present/absent (in response to a stimulus, longitudinal)
 5. Appropriateness: appropriate /inappropriate
 6. Lability: rapid, often exaggerated changes in mood, where string emotions or feelings (uncontrollable laughing or crying, or heightened irritability or temper) occur.

Example:

Affect: (s) – मन परेशान है

(o) – appeared to be anxious

Range – preserved

Reactivity – present

Appropriate

5. Thought :

- Normal thinking is a goal directed flow of ideas, symbols and associations initiated by a problem or a task, characterised by rational connections between successive ideas or thoughts, and leading towards a reality oriented conclusion. Therefore, ***thought process that is not goal-directed, or not logical, or does not lead to a realistic solution to the problem at hand, is not considered normal.*** Thought is assessed (by the content of speech) under the four headings of stream, form, content and possession of thought.

Thought is described under:

- **Stream of thought**
- **Form of thought**
- **Content of thought**
- **Possession of thought**

Stream [flow] of thought

It is divided in two parts: **Thought TEMPO (speed) and CONTINUITY of thought**. Disorder in thought tempo are flight of ideas, prolixity, poverty of content of speech, circumstantiality.

Defect in 'continuity' of thought:

Perseveration - persistent and inappropriate repetition of same thought or verbal response

Example:

Q. What is your name- xyz,

Q. where do you live –xyz

Q. What do you do? – xyz

Thought block - sudden interruption/brake in train/continuity of thought

Form of thought

*Form of thought or thought process differs from thought content in that it does not describe what the person is thinking rather how the thoughts are **formulated, organized, and expressed**.*

A patient can have normal thought process with significantly delusional thought content. Conversely, there may be generally normal thought content but significantly impaired thought process. Normal thought process is typically described as linear, organized, and goal-directed. The abnormal thought process is described as flight of idea, tangentiality, circumstantiality, perseveration, thought block, neologism, poverty of speech, etc. In poverty of speech, there is very less speech output whereas in poverty of content of speech, there may be a large amount of speech but it would convey no meaningful message.

Disorder of form is assessed by checking whether - loosening of associations/derailment.

- **Derailment:** A pattern of spontaneous speech in which the ideas slip off the track onto another one that is clearly but obliquely related, or onto one that is completely unrelated.

Things may be said in juxtaposition that lack a meaningful relationship, or the patient may shift idiosyncratically from one frame of reference to another. At times, there may be a vague connection between the ideas; at others, none will be apparent. This pattern of speech is often characterized as sounding "disjointed".

For Example:

Interviewer: "What did you think of the whole Watergate affair?"

Patient: "You know I didn't tune in on that, I felt so bad about it. I said, boy, I'm not going to know what's going on in this. But it seemed to get so murky, and everybody's reports were so negative. Huh, I thought, I don't want any part of this, and I was I don't care who was in on it, and all I could figure out was Artie had something to do with it. Artie was trying to flush the bathroom toilet of the White House or something. She was trying to do something fairly simple. The tour guests stuck or something. She got blamed because of the water overflowed, went down in the basement, down, to the kitchen. They had a, they were going to have to repaint and restore the White House room, the enormous living room. And then it was at this reunion they were having. And it's just such a mess and I just thought, well, I'm just going to pretend like I don't even know what's going on. So I came downstairs and 'cause I pretended like I didn't know what was going on, I slipped on the floor of the kitchen, cracking my toe, when I was teaching some kids how to do some double dives."

- **Flight of ideas:** The patient rapidly moves from one thought to another, at a pace that is difficult for the listener to keep up with, but all of the ideas are logically connected.
- **Circumstantiality:** in response to a question patient give very unnecessary trivial details before actually answering the question. A circumstantial patient over includes details and materials that is not directly relevant to the subject or answers of the question but does eventually returns to the subject or answer of the question. In the process of explaining something, the speaker brings in many tedious details and sometimes makes parenthetical remarks. Circumstantial replies or statements may last for many minutes if the speaker is not interrupted and urged to get to the point. Interviewers will often recognize circumstantiality on the basis of needing to interrupt the speaker to complete

the process of history-taking within an allotted time. This form of speech is very common in normal individuals too.

- **Tangentiality:** Tangential thought process may at first appear similar, but the patient never returns to the original point or question. The tangential thoughts are seen as irrelevant and related in a minor, insignificant manner. In response to a question patient gives answer which is relevant to the general topic without actually answering the questions. Replying to a question in an oblique, tangential, or even irrelevant manner. The reply may be related to the question in some distant way or the reply may be unrelated and seem totally irrelevant.

For example:

Interviewer: "What city are you from?"

Patient: "Well that's a hard question to answer because my parents. ... I was born in Iowa, but I know that I'm white instead of black so apparently I came from the North somewhere and I don't know where, you know, I really don't know where my ancestors came from. So I don't know whether I'm Irish or French or Scandinavian or I don't I don't believe I'm Polish but I think I'm I think I might be German or Welsh. I'm not but that's all speculation and that that's one thing that I would like to know and is my ancestors you know where where did I originate. But I just never took the time to find out the answer to that question."

- **Perseveration:** The tendency to focus on a specific idea or content without the ability to move on to other topics. The patient repeatedly comes back to the same topic despite the interviewer's attempts to change the subject.
- **Thought blocking:** refers to a disordered thought process in which the patient appears to be unable to complete a thought. Patient may stop mid-sentence and leave the interviewer waiting for the completion. When asked about this, patients often remark that they don't know what happened and may not remember what was being discussed.
- **Neologisms:** refer to a new word or condensed combination of several words that is not a true word and is not readily understandable although sometimes the intended meaning or partial meaning may be apparent.

- **Word salad** is speech characterized by confused, and often repetitious, language with no apparent meaning or relationship attached to it.

Note: The best way to elicit a thought process abnormality is to give an open ended question or give a specific topic to the patient and ask them to speak for some time on the same, for example, “tell me something about the school which you went to”.

- **Other disorders of form are:** incoherence, illogicality of content
- **Content of thought**
 - Thought content is essentially what thoughts are occurring to the patient or the meaning of the words expressed by the patient during the interview.
 - This is inferred by what the patient spontaneously expresses, as well as responses to specific questions aimed at eliciting particular pathology. For example, a depressed patient may think that his future is bleak and constantly ruminate about this, while the anxious patient may worry about more daily occurrences
 - **Delusions:** are false, fixed ideas that are held despite evidence to contrary and are not shared by others from the same socio-cultural and educational background. Questions that can be helpful include, “do you ever feel that people around are all looking at you/ like someone is following you/ want to harm you,” and “do you feel like the TV or radio has a special message for you?”
 - **Types of delusions:** Delusion of persecution, reference, grandeur, love, jealousy (infidelity), guilt, nihilism, poverty, somatic (hypochondriacal).
 - Suicidality and homicidality also needs to be documented under the category of thought content. One must enquire in detail about ideation, intent, plan, and preparation. The assessment of both suicidal and homicidal thoughts and impulses include whether there is a contingency involved (if this happens then I will commit suicide), whether the thoughts are new or chronic, and what prevents the patient from acting on them.
 - It is important to remember that besides the psychopathology expressed by the patient as part of the thought content, the therapist should also actively question the patient to cover the whole range of psychopathology and document the presence and absence of various abnormalities.

- **Description of Delusions in MSE:**

- 1. False- firm-fixed belief of morbid origin, not culturally shared**

- 2. Content - type**

- 3. Single/multiple**

- 4. Elaborated**

- 5. Systematized**

- 6. Primary/secondary**

- 7. Mood congruity**

- 8. Acting out**

- 9. Affect associated with**

- 10. Special types**

- **Possession of thought:** Sometimes person loses control on their own thinking and have either- Obsessions (recurrent, irrational, intrusive, ego-dystonic), not regarded as being foreign and outside their control or other outside agency is controlling thinking of patient or that others are participating in their thinking (thought insertion/ withdrawal/ broadcasting). Thought alienation is part of the first rank symptoms of Schneider. These include thought insertion, thought withdrawal and thought broadcasting.
- **Thought insertion - example :** One man said that thoughts were being put into his mind and that they “felt different” from his own; another said that the television and radio were responsible for different thoughts, which were “tampered with electrically” and always felt the same way (i.e. recognizably different from his “own”)
- **Thought broadcast - example:** A 21-year-old student said, “As I think, my thoughts leave my head on a type of mental ticker-tape. Everyone around has only to pass the tape through their mind and they know my thoughts”.
- **Obsessions- example :** A 20 year old male with obsessions of doubt and contamination said *“I get thoughts that my hands are dirty even after cleaning several times, these thoughts come one after other, again and again several times till I repeat my act of cleaning hands again. I know these are my own thoughts and are absurd but I am unable to resist these thoughts. If ever I try to resist them, there occurs severe anxiety and I feel restless and I have to clean my hands with soap and water. I feel helpless and its beyond my control to resist these thoughts”.*

Perception/Perceptual disturbances

- Perception means process by which information which we are receiving via our 5 sensory organs are meaningfully arranged and decoded/interpreted by our brain by comparing it with our previous experiences.
- Perceptual disturbances include hallucinations, illusions, depersonalization, and derealization.
- Hallucinations are perceptions that occur to an individual in the absence of stimuli to account for the same.
- Depersonalization is a feeling that one is not oneself or that something has changed in oneself.
- Derealization is a feeling that one's environment has changed in some strange way that is difficult to describe.
- **Hallucinations**
 - Auditory hallucinations are the hallucinations most frequently encountered in the psychiatry setting. Other hallucinations can include visual, tactile, olfactory, and gustatory (taste).
 - Distinction between a true hallucination and a misperception of stimuli (illusion) needs to be made. Hearing the wind rustle through the trees outside one's bedroom and thinking a name is being called is an illusion. Hypnagogic hallucinations (at the interface of wakefulness and sleep) may be normal phenomena. At times, patients without psychosis may hear their name called or see flashes or shadows out of the corner of their eyes.
 - In describing hallucinations, the interviewer should include what the patient is experiencing, when it occurs, how often it occurs, and whether it is uncomfortable (ego dystonic) or not, how many voices were heard, in which part of the day, male or female voices, how interpreted and whether these are second person or third person hallucinations (i.e. whether the voices were addressing the patient or were discussing between themselves); also enquire about command (imperative) hallucinations (which give commands to the person). Enquire whether the hallucinations occurred during wakefulness, or were they hypnagogic (occurring while going to sleep) and/or hypnopompic (occurring while getting up from sleep) hallucinations.

Description of hallucinations in MSE:

1. Perception – differentiate from thought

2. False

3. Timing - awake / hypnagogic/hypnopompic – differentiate from dream

4. Modality – visual/auditory/tactile/gustatory/somatic

5. Description

- **Intensity**
- **Distance**
- **Content**
- **Frequency**
- **No of persons**
- **Duration**
- **Location**
- **Constancy**
- **Overt behaviour**
- **Control**
- **Experiences shared**
- **Attitude towards hallucinations**
- **Clarity**
- **Insight**
- **Any precipitating factor**

Example : “I hear voices of two persons¹ talking with each other. These are female voices¹, of my aunt and neighbor². These voices are as clear³ as I am listening to you and audible from ear. I am able to hear the other surrounding sound as well at the same time⁴. The voices come from outside⁵; from a distance of about 10-15 m⁵. I hear these voices 4-5 times a day⁶ for around 10-15 min⁷ each time continuously⁸. At times, I hear them at normal volume⁹ at other time they whisper. They keep talking ill things¹⁰ about me. I feel sad and get angry¹¹. I tried to go out and find them but could not find them. I at times cover my ear with hand¹². But still not much relief. I have no control¹³ over these voices. These voices seem real¹⁴ to me. I think that other person nearby should be able to hear them, but my family member denies¹⁵ hearing any such voices”
[(1-Number/ Gender, 2- Known/Unknown,3- Clarity,4- Consciousness,5- Location/Distance,6-

Frequency,7- Duration,8- Constancy,9- Intensity,10-Content,11-Affect,12- Behavior/acting out,13- Control,14- Reality,15- Experiences shared)]

6. Cognitive Functions

- It is the assessment of the cognitive or higher mental functions. Any disturbance of cognitive functions commonly points to the presence of an organic psychiatric disorder.
- The elements of cognitive functioning that should be assessed are level of consciousness, attentiveness/alertness, orientation, concentration, memory (both short and long term), calculation, fund of knowledge, abstract reasoning, insight, and judgment.
- There are structured tests which can be used to assess all the above cognitive functions. However, it is important to remember that these tests can be applied universally and at time socio-cultural adaptation may be required.
- Another important aspect of cognitive function evaluation is that the therapist should tell the patient before had that they may be administering certain simple tests to get an idea about the patient's cognitive status, because at times patients may feel as to why such simple silly questions are asked to them and may consider that evaluation was demeaning to their status.
- **Consciousness**
 - The intensity of stimulation needed to arouse the patient will demonstrate the level of alertness, for example, by calling patient's name in a normal voice, calling in a loud voice, light touch on the arm, vigorous shaking of the arm, or painful stimulus.
 - Grade the level of consciousness: conscious/
confusion/somnolence/clouding/delirium/stupor/coma.
- **Orientation**
 - Whether the patient is well oriented to time (test by asking the time, date, day, month, year, season, and the time spent in hospital), place (test by asking the present location, building, city, and country) and person (test by asking his own name, and whether he can identify people around him and their role in that environment).
 - Disorientation in time usually precedes disorientation in place and person. Orientation to self is lost at last.
 - First ask orientation to time then place and then person, lastly check if he is able to name himself/herself.

- **How to describe :**

- Oriented to time, place and person
- Not Oriented to time, place and person
- Not Oriented to time and place but oriented to person

- **Attention**

- Attention is the patient's ability to attend to a specific stimulus without being distracted by extraneous internal or environmental stimuli

It is checked by asking the patient

- Digit repetition : Repeat digits forwards and backwards (digit span test; digit forward and backward test), one at a time (for example, patient may be able to repeat 5 digits forward and 3 digits backwards)
- Start with two digit numbers increasing gradually up to eight digit numbers or till failure occurs on three consecutive occasions.
- Alternatives : spell the word "WORLD" backwards etc. can be tried

TEST ITEMS	
3-7	9-2
7-4-9	1-7-4
8-5-2-7	5-2-9-7
2-9-6-8-3	6-3-8-5-1
5-7-2-9-4-6	2-9-4-7-3-8
8-1-5-9-3-6-2	4-1-9-2-7-5-1
3-9-8-2-5-1-4-7	8-5-3-9-1-6-2-7
7-2-8-5-4-6-7-3-9	2-1-9-7-3-5-8-4-6

- **Concentration:** Sustained attention (concentration) is the ability to maintain attention to a specific stimulus over an extended period.

- Ask the patient to subtract serial sevens from hundred (100-7test), or serial threes from fourty (40-3 test), or to count backwards from 20 to 1, or enumerate the names of the months (or days of the week) in the reverse order.
- Note down the answers and the time taken to perform the tests.
- Results of studies of performance by normal people suggest that errors on this test may be influenced by Intellectual capability, education, calculating ability, or socioeconomic status, rather than indicating a pathologic process. Excellent performance indicates

adequate attention or mental control, but failure may reflect any of a number of problems, inattention being but one.

- Time duration :

Serial Sevens Subtraction Test: 100-7 (time, mistakes) -**150 sec**, 40-3 (time, mistakes)-**90 sec**, 20-1 (time, mistakes)-**30 sec**

- Illiterate person: Reverse days of the week and reverse months of the year can be asked.

- **Memory:**

- Clinically memory is divided into 3 types, based on the time span between stimulus presentation and memory retrieval
- Immediate Retention and Recall (IR and R) :is used to recall a memory trace after an interval of a few seconds/ few minutes, as in the repetition of a series of digits.. Immediate memory is tested by – registration and recall. Registration of the patient tested by asking the patient to repeat three words (*for example “school, purple, honesty”*) after the interviewer. Recall is tested by asking the patient to recollect the three words given 3 minutes earlier.
- Recent Memory: is the patient’s capacity to remember current, day-to-day events (e.g., the current date, the doctor’s name, breakfast or recent new events).It is the ability to learn new material and to retrieve that material after an interval of minutes, hours, or days
- Remote Memory: recall of facts or events that occurred years previously (e.g., names of teachers and old school friends, birth dates, and historic facts).Ask for the date and place of marriage, name and birthdays of children, any other relevant questions from the person’s past. Check for any amnesia (anterograde/ retrograde), or confabulation, if present.

- **Intelligence and fund of knowledge:**

- Intelligence is defined as ability to think logically, act rationally, and deal effectively with environment.
- General fund of knowledge should be asked keeping in mind the patient’s educational and social background, his experiences and interests, for example, ask about the current and the past prime ministers, sarpanch of village and presidents of India, the capital of India, and how the wall/tea is made [complete procedure]

Test for reading and writing; Use simple tests of calculation, like $5 + 9 = ?$, $3 \times 7 = ?$

- **Calculations:** calculation ability - by giving the patient simple and complex calculations, starting from single digit to double digits and then more complex calculations, starting from addition and then moving to subtraction, multiplication and division.
 - Addition, Subtraction, Multiplication & Division
 - Verbal, Written
 - Simple, complex
 - Sequence (*correct sequence*): Simple written, Simple verbal, Complex written and Complex verbal
- **Comprehension:**
 - Comprehension is the ability to understand and get meaning from spoken and written language
 - Comprehension is comprised of a complex process involving knowledge, experience, thinking, and teaching
 - Comprehension is the understanding and interpretation of what is read
 - To be able to accurately understand written material, there is a need to be able to decode what they read, make connections between what they read and what they already know; and think deeply about what they have read
 - How to assess : by narrating simple stories which have a moral and asking the patient to tell the moral of the story
 - Telling Stories: Ask the patient about a particular story, Ask the patient to tell the story, Ask the patient what is the moral of the story or what do we learn from the story. Common stories used : Rabbit and Tortoise and Thirsty Crow Story
 - Alternative: Tell the story to the patient, which he may or may not be familiar, Ask the patient what is the moral of the story or what do we learn from the story
- **Abstract thinking :**
 - Abstract reasoning is the ability to break whole into its parts and to construct whole from its parts. It is also the ability to shift back and forth between general concepts and specific examples. Having the patient identify similarities between like objects or concepts (apple and pear, bus and airplane, or a poem and a

painting) as well as interpreting proverbs can be useful in assessing one's ability to abstract.

- Cultural and educational factors and limitations should be kept in mind when assessing ability to abstract. Abstraction means the concept which cannot be seen and touched it can only be understood/conceptualized. The methods used are:
- **Proverb interpretation:** The meaning of simple proverbs are usually asked:
 - ‘‘जैसी करनी वैसी भरनी – का क्या मतलब होता है ?
 - ‘‘बन्दर क्या जाने अदरक का स्वाद’’
- **Interpretation :** For example

How to go about ? Don't cry over spilled milk

0 – **concrete** – the milk is all over the floor, when the milk is on the floor you can't use it.; don't cry.

1- **semi abstract** - it's gone, don't worry about it ;don't cry when something goes wrong

2 – **abstract** – once something is over don't worry about it ;don't be concerned about events that are beyond control or have happened wrongly or rightly.

- **Similarity testing (and also the differences-usually 3) between familiar objects should be asked, such as:** table/chair; banana/orange; dog/lion[both are animals-Abstract answer]; bus/car [Abstract answer- both are means of transportation - this means of transportation is a concept which can only be understood; Concrete answer (focusing on external features)- both have 4 wheels, steering, seat for sitting]. The answers may be concrete or abstract.

- **Judgement:**

- Judgement is the ability of the person to take sound/correct decisions and act effectively on them ‘or’ ability to assess a situation correctly and act appropriately within that situation. It has 2 parts social and test judgement.

- ***Social judgement:***

- It includes basic knowledge of social situations, knowledge of the socially appropriate responses in such situations and the ability to apply the correct responses personally when faced with an actual social situation

- Impression based on observations of others who have witnessed the patient's actual performance in dealing with day to day events
- **Test judgement:**
 - Place the patient in an actual, but experimental, situations that require an immediate, appropriate response
 - Tell the patient that she/he will be presented with a situation and she/he has to give a response that she/he think is the most effective in dealing with the situation
 - Realistic/ hypothetical situations – may use a test, depending on the patients profession/day to day functioning
 - Tailor-made to suit the individual role requirements :Fire story, Letter story

Fire story: Suppose you are walking on the street, you see smoke and fire coming out of the building, what would you do?

Suppose, you are sitting in a room, there is a fire, what would you do?. Suppose, you are sitting in a room, there is a fire (big fire) in the room, what would you do?

Letter story:

Suppose you are walking on the street, you see a letter lying on the ground, what would you do ?.

Suppose you are walking on the street, you see a letter lying on the ground, you pick it up, see the letter has address of someone in a different city, what would you do ?.

Suppose you are walking on the street, you see a letter lying on the ground, you pick it up, see the letter has address of someone in a different city, it has a postage stamp on it, what would you do ?

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

5. Insight

- Insight, in the psychiatric evaluation, refers to the patient's understanding of whether they have an illness, whether this illness is physical or psychological, what is the cause of the illness and whether they need treatment, what would be their role in treatment etc.

- Depending on the assessment, the patient may have no insight, partial insight, or full insight. Insight is generally lost in psychosis. The amount of insight is not an indicator of the severity of the illness.
- The correct attitude to morbid change in oneself (Aubrey Lewis).
- Awareness of illness; and the extension of this awareness to all the symptoms, illness as a whole, with an objectively correct estimate of the severity and judgment of its particular type (Jaspers).
- David: 3 dimensions, Amador: 5 dimensions (awareness of symptoms, illness, consequences and effects of medications; attribution), 6 grades (CTP 2nd edition)
- Insight is the degree of awareness and understanding that the patient has about his/her illness. Insight is rated on a 6-point scale from one to six.
 1. Complete denial of illness.
 2. Slight awareness of being sick and needing help, but denying it at the same time.
 3. Awareness of being sick, but it is attributed to external or physical factors.
 4. Awareness of being sick, due to something unknown in self.
 5. Intellectual Insight: Awareness of being ill and that the symptoms/failures in social adjustment are due to own particular irrational feelings/thoughts; yet does not apply this knowledge to the current/future experiences.
 6. True Emotional Insight: It is different from intellectual insight in that the awareness leads to significant basic changes in the future behaviour

Components (Comprehensive)

- **Recognition that one has a mental illness**
- **Awareness of specific signs and symptoms of the disorder**
- **Ability to label unusual mental events as pathological**
- **The attribution of symptoms to disorder**
- **Understanding of the social consequences of disorder**
- **Awareness about the cause of the disorder**
- **Awareness of the need of treatment (short term/long term)**
- **Aware about personal role in the treatment**
- **Aware about the need for change in self**
- **Adherence to treatment**

For example:

- आपको क्या परेशानी है, दिक्कत है, बीमारी है
- आपके हिसाब से इस बीमारी के क्या लक्षण होते हैं
- आपके हिसाब से आपको इस बीमारी के किन-किन लक्षण का सामना करना पड़ा
- आपके हिसाब से क्या यह सब एक ही बीमारी के लक्षण हो सकते हैं
- इस बीमारी का आपके जीवन पर / सामाजिक जीवन पर क्या असर हुआ है
- आपके हिसाब से इस बीमारी का क्या कारण है, आपको यह बीमारी क्यों हुई
- आपके हिसाब से क्या इलाज की जरूरत है, किस तरह के इलाज की जरूरत है, कितने समय के लिए जरूरत है, इलाज किस तरह से चलेगा, दवाई कब तक और किस तरह से खानी पड़ेगी, दवा कितने नियमित तरीके से लेनी होगी, Sessions के लिए आपको क्या करना पड़ेगा
- इलाज में आपका क्या रोल होगा
- क्या आपको अपने आपको बदलना होगा, क्या आपको इलाज द्वारा अपने आपको बदलना होगा

GLOSSARY OF COMMON TERMS (From DSM-5 & ICD-10)

- **Affect** -A pattern of observable behaviors that is the expression of a subjectively experienced feeling state (emotion). Examples of affect include sadness, elation, and anger.
 - **Blunted** Significant reduction in the intensity of emotional expression.
 - **Flat** Absence or near absence of any sign of affective expression.
 - **Inappropriate** Discordance between affective expression and the content of speech or ideation.
 - **Labile** Abnormal variability in affect with repeated, rapid, and abrupt shifts in affective expression.
 - **Restricted or constricted** Mild reduction in the range and intensity of emotional expression.
- **Anhedonia** - Lack of enjoyment from, engagement in, or energy for life's experiences; deficits in the capacity to feel pleasure and take interest in things.
- **Anxiety**- The apprehensive anticipation of future danger or misfortune accompanied by a feeling of worry, distress, and/or somatic symptoms of tension. The focus of anticipated danger may be internal or external.
- **Attention** - The ability to focus in a sustained manner on a particular stimulus or activity.
- **Compulsion** - Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession, or according to rules that must be applied rigidly. The behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive
- **Delusion** A false belief based on incorrect inference about external reality that is firmly held despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary. The belief is not ordinarily accepted by other members of the person's culture or subculture (i.e., it is not an article of religious faith). When a false belief involves a value judgment, it is regarded as a delusion only when the judgment is so extreme as to defy credibility. Delusions are subdivided according to their content. Common types are listed below:

- **Bizarre** A delusion that involves a phenomenon that the person's culture would regard as physically impossible.
- **Delusional jealousy** A delusion that one's sexual partner is unfaithful.
- **Erotomaniac** A delusion that another person, usually of higher status, is in love with the individual.
- **Grandiose** A delusion of inflated worth, power, knowledge, identity, or special relationship to a deity or famous person.
- **Mixed type** Delusions of more than one type (e.g., erotomaniac, grandiose, persecutory, somatic) in which no one theme predominates.
- **Of being controlled** A delusion in which feelings, impulses, thoughts, or actions are experienced as being under the control of some external force rather than being under one's own control.
- **Of reference** A delusion in which events, objects, or other persons in one's immediate environment are seen as having a particular and unusual significance. These delusions are usually of a negative or pejorative nature but also may be grandiose in content. A delusion of reference differs from an *idea of reference*, in which the false belief is not as firmly held nor as fully organized into a true belief.
- **Persecutory** A delusion in which the central theme is that one (or someone to whom one is close) is being attacked, harassed, cheated, persecuted, or conspired against.
- **Somatic** A delusion whose main content pertains to the appearance or functioning of one's body.
- **Thought broadcasting** A delusion that one's thoughts are being broadcast out loud so that they can be perceived by others.
- **Thought insertion** A delusion that certain of one's thoughts are not one's own, but rather are inserted into one's mind
- **Depersonalization** The experience of feeling detached from, and as if one is an outside observer of, one's mental processes, body, or actions (e.g., feeling like one is in a dream; a sense of unreality of self, perceptual alterations; emotional and/or physical numbing; temporal distortions; sense of unreality).

- **Disorientation** Confusion about the time of day, date, or season (time); where one is (place); or who one is (person).
- **Dissociation** The splitting off of clusters of mental contents from conscious awareness.
- **Distractibility** Difficulty concentrating and focusing on tasks; attention is easily diverted by extraneous stimuli; difficulty maintaining goal-focused behavior, including both planning and completing tasks.
- **Echolalia** The pathological, parrot like, and apparently senseless repetition (echoing) of a word or phrase just spoken by another person.
- **Echopraxia** Mimicking the movements of another.
- **Emotional lability** Instability of emotional experiences and mood; emotions that are easily aroused, intense, and/or out of proportion to events and circumstances.
- **Empathy** Comprehension and appreciation of others' experiences and motivations; tolerance of differing perspectives; understanding the effects of own behavior on others.
- **Episode (episodic)** A specified duration of time during which the patient has developed or experienced symptoms that meet the diagnostic criteria for a given mental disorder.
- **Fear** An emotional response to perceived imminent threat or danger associated with urges to flee or fight.
- **Flight of ideas** A nearly continuous flow of accelerated speech with abrupt changes from topic to topic that are usually based on understandable associations, distracting stimuli, or plays on words. When the condition is severe, speech may be disorganized and incoherent.
- **Grandiosity** Believing that one is superior to others and deserves special treatment; selfcenteredness; feelings of entitlement; condescension toward others
- **Hallucination** A perception-like experience with the clarity and impact of a true perception but without the external stimulation of the relevant sensory organ. Hallucinations should be distinguished from ILLUSIONS, in which an actual external stimulus is misperceived or misinterpreted. The person may or may not have insight into the nonveridical nature of the hallucination. One hallucinating person may recognize the false sensory experience, whereas another may be convinced that the experience is grounded in reality.
 - The term *hallucination* is not ordinarily applied to the false perceptions that occur during dreaming, while falling asleep (*hypnagogic*), or upon awakening (*hypnopompic*).

- **Auditory** A hallucination involving the perception of sound, most commonly of voice.
- **Geometric** Visual hallucinations involving geometric shapes such as tunnels and funnels, spirals, lattices, or cobwebs.
- **Gustatory** A hallucination involving the perception of taste (usually unpleasant).
- **Olfactory** A hallucination involving the perception of odor, such as of burning rubber or decaying fish.
- **Somatic** A hallucination involving the perception of physical experience localized within the body (e.g., a feeling of electricity). A somatic hallucination is to be distinguished from physical sensations arising from an as-yet-undiagnosed general medical condition, from hypochondriacal preoccupation with normal physical sensations, or from a tactile hallucination.
- **Tactile** A hallucination involving the perception of being touched or of something being under one's skin. The most common tactile hallucinations are the sensation of electric shocks and formication (the sensation of something creeping or crawling on or under the skin).
- **Visual** A hallucination involving sight, which may consist of formed images, such as of people, or of unformed images, such as flashes of light. Visual hallucinations should be distinguished from ILLUSIONS, which are misperceptions of real external stimuli
- **Hypomania** An abnormality of mood resembling mania but of lesser intensity
- **Illusion** A misperception or misinterpretation of a real external stimulus, such as hearing the rustling of leaves as the sound of voices.
- **Incoherence** Speech or thinking that is essentially incomprehensible to others because word or phrases are joined together without a logical or meaningful connection. This disturbance occurs *within* clauses, in contrast to derailment, in which the disturbance is *between* clauses. This has sometimes been referred to a “word salad” to convey the degree of linguistic disorganization.
- **Magical thinking** The erroneous belief that one's thoughts, words, or actions will cause or prevent a specific outcome in some way that defies commonly understood laws of cause and effect. Magical thinking may be a part of normal child development.

- **Mania** A mental state of elevated, expansive, or irritable mood and persistently increased level of activity or energy.
- **Mood** A pervasive and sustained emotion that colors the perception of the world. Common examples of mood include depression, elation, anger, and anxiety. In contrast to *affect*, which refers to more fluctuating changes in emotional “weather,” mood refers to a pervasive and sustained emotional “climate.” Types of mood include
 - **Dysphoric** An unpleasant mood, such as sadness, anxiety, or irritability.
 - **Elevated** An exaggerated feeling of well-being, or euphoria or elation. A person with elevated mood may describe feeling “high,” “ecstatic,” “on top of the world,” or “up in the clouds.”
 - **Euthymic** Mood in the “normal” range, which implies the absence of depressed or elevated mood
 - **Expansive** Lack of restraint in expressing one’s feelings, frequently with an overvaluation of one’s significance or importance.
 - **Irritable** Easily annoyed and provoked to anger
- **Mood-congruent psychotic features** Delusions or hallucinations whose content is entirely consistent with the typical themes of a depressed or manic mood. If the mood is depressed, the content of the delusions or hallucinations would involve themes of personal inadequacy, guilt, disease, death, nihilism, or deserved punishment. The content of the delusion may include themes of persecution if these are based on self-derogatory concepts such as deserved punishment. If the mood is manic, the content of the delusions or hallucinations would involve themes of inflated worth, power, knowledge, or identity, or a special relationship to a deity or a famous person. The content of the delusion may include themes of persecution if these are based on concepts such as inflated worth or deserved punishment.
- **Mood-incongruent psychotic features** Delusions or hallucinations whose content is not consistent with the typical themes of a depressed or manic mood.
- **Mutism** No, or very little, verbal response (in the absence of known aphasia).
- **Negativism** Opposition to suggestion or advice; behavior opposite to that appropriate to a specific situation or against the wishes of others, including direct resistance to efforts to be moved.

- **Overvalued idea** An unreasonable and sustained belief that is maintained with less than delusional intensity (i.e., the person is able to acknowledge the possibility that the belief may not be true). The belief is not one that is ordinarily accepted by other members of the person's culture or subculture.
- **Perseveration** Persistence at tasks or in particular way of doing things long after the behavior has ceased to be functional or effective; continuance of the same behavior despite repeated failures or clear reasons for stopping.
- **Personality** Enduring patterns of perceiving, relating to, and thinking about the environment and oneself. PERSONALITY TRAITS are prominent aspects of personality that are exhibited in relatively consistent ways across time and across situations. Personality traits influence self and interpersonal functioning. Depending on their severity, impairments in personality functioning and personality trait expression may reflect the presence of a personality disorder.
- **Phobia** A persistent fear of a specific object, activity, or situation (i.e., the phobic stimulus) out of proportion to the actual danger posed by the specific object or situation that results in a compelling desire to avoid it. If it cannot be avoided, the phobic stimulus is endured with marked distress.
- **Posturing** Spontaneous and active maintenance of a posture against gravity
- **Psychomotor agitation** Excessive motor activity associated with a feeling of inner tension. The activity is usually nonproductive and repetitious and consists of behaviors such as pacing, fidgeting, wringing of the hands, pulling of clothes, and inability to sit still.
- **Psychomotor retardation** Visible generalized slowing of movements and speech.
- **Racing thoughts** A state in which the mind uncontrollably brings up random thoughts and memories and switches between them very quickly. Sometimes the thoughts are related, with one thought leading to another; other times they are completely random. A person experiencing an episode of racing thoughts has no control over them and is unable to focus on a single topic or to sleep.
- **Rapid cycling** Term referring to bipolar disorder characterized by the presence of at least four mood episodes in the previous 12 months that meet the criteria for a manic, hypomanic, or major depressive episode. Episodes are demarcated either by partial or full remissions of at least 2 months or by a switch to an episode of the opposite polarity (e.g., major depressive

episode to manic episode). The rapid cycling specifier can be applied to bipolar I or bipolar II disorder

- **Stress** The pattern of specific and nonspecific responses a person makes to stimulus events that disturb his or her equilibrium and tax or exceed his or her ability to cope.
- **Stressor** Any emotional, physical, social, economic, or other factor that disrupts the normal physiological, cognitive, emotional, or behavioral balance of an individual.
- **Stressor, psychological** Any life event or life change that may be associated temporally (and perhaps causally) with the onset, occurrence, or exacerbation of a mental disorder.
- **Stupor** Lack of psychomotor activity, which may range from not actively relating to the environment to complete immobility
- **Suicidal ideas (suicidal ideation)** Thoughts about self-harm, with deliberate consideration or planning of possible techniques of causing one's own death.
- **Suicide** The act of intentionally causing one's own death.
- **Suicide attempt** An attempt to end one's own life, which may lead to one's death.
- **Suspiciousness** Expectations of—and sensitivity to—signs of interpersonal ill intent or harm; doubts about loyalty and fidelity of others; feelings of being mistreated, used, and/or persecuted by others.
- **Symptom** A subjective manifestation of a pathological condition. Symptoms are reported by the affected individual rather than observed by the examiner.
- **Syndrome** A grouping of signs and symptoms, based on their frequent co-occurrence that may suggest a common underlying pathogenesis, course, familial pattern, or treatment selection.
- **Tic** An involuntary, sudden, rapid, recurrent, nonrhythmic motor movement or vocalization
- **Worry** Unpleasant or uncomfortable thoughts that cannot be consciously controlled by trying to turn the attention to other subjects. The worrying is often persistent, repetitive, and out of proportion to the topic worried about (it can even be about a triviality)

References for further reading:

- **Fish Textbook of Psychopathology**
- **Sim's Textbook of Psychopathology**

- **Kaplan and Saddock Comprehensive Textbook of Psychiatry, 9th and 10th Ed.**
- **Andreasen NC. Thought, language, and communication disorders. I. Clinical assessment, definition of terms, and evaluation of their reliability. Arch Gen Psychiatry. 1979 Nov;36(12):1315-21.**