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Assessment of the Psychological State

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Abstract
A psychiatric examination consists of four parts:

1. The psychiatric history
2. Examination of the Mental State
3. Evaluation of the personality
4. The diagnostic formulation

The clinical method for history-taking is the interview. The clinician sets out to obtain a comprehensive history in his first interview with the patient. A series of interviews may be necessary before he acquires all the information he needs to understand both how the psychiatric illness came about and why it took the course it did. In his first interview the goal of the clinician is to get at least a preliminary overall *history*; in doing so, he will also detect the prominent signs or illness comprising the *mental state;* moreover, he will have the information enabling him to reach a tentative assessment of the patient's *personality;* and he will be able to arrive at a working *diagnosis.* A diagnosis is an hypothesis about the illness; and about the main aetiological factors operating. It is derived by the clinician from an informed synthesis of the facts elicited. Because diagnosis antecedes therapy, and the clinician will wish to begin the initial treatment after his first interview, he aims to reach his preliminary diagnosis where possible. A first interview takes an experienced practitioner half-an-hour. Subsequent interviews may be briefer, and can be arranged as required to get further information and to extend the psychiatric examination as necessary.

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ASSESSMENT OF THE PHYCHOLOGICAL STATE

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INTRODUCTION

A psychiatric examination consists of four parts :

1. The psychiatric history
2. Examination of the Mental State
3. Evaluation of the personality
4. The diagnostic formulation

The clinical method for history-taking is the interview. The clinician sets out to obtain a comprehensive history in his *first* interview with the patient. A series of interviews may be necessary before he acquires all the information he needs to understand both how the psychiatric illness came about and why it took the course it did. In his first interview the goal of the clinician is to get at least a preliminary overall *history*; in doing so, he will also detect the prominent signs or illness comprising the *mental state*; moreover, he will have the information enabling him to reach a tentative assessment of the patient's *personality*; and he will be able to arrive at a working *diagnosis*. A diagnosis is an hypothesis about the illness; and about the main aetiological factors operating. It is derived by the clinician from an informed synthesis of the facts elicited. Because diagnosis antecedes therapy, and the clinician will wish to begin the initial treatment after his first interview, he aims to reach his preliminary diagnosis where possible. A first interview takes an experienced practitioner half-an-hour. Subsequent interviews may be briefer, and can be arranged as required to get further information and to extend the psychiatric examination as necessary.

A theoretical knowledge of interviewing procedure is essential, but is not sufficient. Psychiatric interviewing is a practical skill which can be learnt only through actual experience with real patients. Furthermore, regular supervision is needed if technical errors are to be identified and progressively corrected. An invaluable aid is provided by the use of video-tape; the trainee interviewer has his psychiatric examination of the patient televised, and when re-played subsequently he and his instructor have the actual clinical data before them for review.

Another important training method is obtained from watching experienced interviewers at work.

When conducting a psychiatric examination the clinician inevitably makes use of his own personality: he relies on his own capacity for communication. He seeks to gain an objective view of the extent to which he succeeds in expressing himself as he intends. His instructor and such aids as tape recording and television show him if he is accurate in his impression about the way he affects people.

To conduct a psychiatric examination two chairs are needed, placed more or less at right

angles. The clinician and his patient are then free to look at one another when they wish, without imposing any requirement for fixed stares, as would be suggested if the two chairs were facing. (A directorial station behind the office desk is of course altogether inappropriate.) The room should be quiet and interruptions minimal.

THE CLINICIAN'S APPROACH

A question-and-answer technique which may serve, for example, in a general medical examination is not desired. The psychiatric history should flow smoothly from one topic to a related one, in a sequence meaningful to the patient. The clinician acts as a catalyst. His primary function is to assist the patient to generate a clinically useful account of personal experience. The clinician writes steadily, to obtain an accurate, factual and full record of the interaction. Any questions he asks are noted as well, so that the verbal stimuli offered to the patient are also recorded. A good history is neither nebulous nor abstract. When the patient mentions somebody, that person should be named. e.g. "I was going with a man friend at that time". The clinician asks, "What was his first name?" This is then recorded; if this person again enters the patient's account, in the present or a later examination, he can be rapidly identified and related to the earlier information.

The competent clinician does not take the patient firmly in a dull routine through each step in the sequence of historical areas. He leaves the patient relatively free to reflect, to overcome hesitations, to go back and amplify, and to alter earlier statements as confidence is established. The clinician gently guides the patient, advises him when inconsequential detail threatens to crowd out important events and indicates quite frankly when he thinks the patient is following a blind alley. The clinician's task is to gain possession of the necessary facts in each of the crucial areas.

This apparent discussiveness is easier to permit the more experienced the clinician becomes. It is appropriate for him to indicate quite plainly to evasive patients that he must have the necessary information. He does not need to encourage the patient with phrases of approval or expressions of sympathy. It goes without saying that he never conveys moral censure or disapproval, although unwittingly clinicians sometimes do. He has no call to become autobiographical himself, and tell the patient about his own trying experiences, child rearing practices, or opinions and attitudes.

In the course of the examination the matters about which people are sensitive can be dealt with sensibly and directly as technical data. Behaviours usually regarded as wrong or unusual can be broached without equivocation, no suggestion of moral evaluation entering. e.g. "Have you tried to end your life?" Such an enquiry may be welcomed by a depressed patient as a much needed opportunity to disclose painful impulses towards suicide; in the process, speaking about the suicidal intention may effectively serve to deter the patient from making a suicide attempt. Sexual experience is discussed in terms which the patient is sure to understand, checking where necessary the patient's term for a part of the body or a sexual activity. The contemporary patient will almost certainly know what "masturbation" means, but not inevitably; often the clinician will perceive that more explicit explanations or simpler words are needed to obtain the information he seeks.

While the patient is not constrained to give a formal, choronological and precisely sequential account, the clinician examining the psychiatric patient has a technical task to carry out, a schedule of operations to be performed. This he aims to carry out as methodically as he would examine any other clinical sector, the neurological system, for example. If he has not examined the fundus he will be aware of this omission, and if he neglects to test the plantar responses the trained clinician likewise knows that his examination is incomplete. Similarly with the psychiatric assessment. If the clinician has not found out about the patient's father, his understanding of the patient's personality is the poorer; if the patient's job record has been neglected, the history is also incomplete. The psychiatric examination is a technical skill, within the competence of all clinicians, and is not in any way a nebulous or impressionistic procedure. One can know about a person's mind with more or less certainty according to one's ability to carry out the relevant clinical procedures.

THE PSYCHIATRIC HISTORY

1. *The Description of the Patient:* The patient's name, age, occupation, marital status, sometimes his religious affiliation and — finally — the method of his referral are facts the clinician will want to record. Eliciting such relatively neutral information may be a

useful way of starting the history-taking; the patient is able as he replies to settle in his chair as comfortably as possible, and to assess the situation he finds himself in. The patient also needs an opportunity to size up the clinician as the examination begins.

2. *The Reasons for the Consultation*: The clinician then ascertains why the patient has come, and what the patient requires of him. The patient's reason for the interview may on occasion be straightforward and at times bizarre. The mythical patient who requests a certificate of sanity wants the clinician to study his mind and then pronounce on its stability. The police may send a patient and be equally explicit — e.g. as occurs when a psychiatrist is asked to examine a woman who has harmed her children physically and has then attempted to kill herself. It may be a relative who brings the patient, as occurs when a mother tells the clinician she has been worried recently about her small son, and describes mannerisms which alarm her. The presenting reason for the referral of course may be merely the introductory gambit, to be extended when the clinician has gained the patient's confidence: a man complaining initially of indigestion may later confess that he has actually come on account of impotence.

3. *The Present Illness*: Having established why the patient has requested to be seen, the clinician then obtains a detailed account of the patient's symptoms. Each complaint is to be recorded scrupulously, in terms close to the patient's own. If the patient mentions a pain in the heart, that is to be recorded as his symptom; it should not be translated into clinicalese, such as "praecordial pain". If the clinician rephrases the patient's actual self-description into clinical jargon he sacrifices veracity and impairs his own grasp of the patient's experience of illness. An adequate description of the illness has been reached when the clinician has traced chronologically each manifestation of the disorder.

4. *The Family History* consists of a verbal sketch by the patient of both his parents and of all his brothers and sisters. "You mentioned your father — what sort of person is he?" The question causes some patients to pause in perplexity, until after hesitation they describe the father as one of the best, or portray him as strict but perfectly fair, or as a mean man who terrorized the family when drunk at weekends. The clinician can usually gather whether the father was perceived positively, in a neutral light, or negatively. The importance of this information is that it conveys the role a parent took in a patient's personality formation: a parent is incorporated during growing-up, and constitutes an inner psychological representation forming an aspect of the patient's self.

The *mother* often is characterized with less trouble. Patients fairly readily say whether she was kind and gentle, or two-faced, or a virago who started her persecution before the patient's birth by striving to abort herself. Again, in describing his mother the patient is disclosing a significant relationship which contributed to his character structure.

His position in the *sibship* may be important. If he was an only child, alone with his mother until five years of age when his father was demobilized from the army, then to have a baby sister arrive on the scene, the patient may proceed to describe a rivalry which agitated his childhood and coloured his subsequent adult social relationships with envy and competitiveness. The size of the sibship is obviously relevant. The clinician's perception of the parental family is filled out when the patient is asked to comment on the *general* atmosphere which existed in the home.

5. The *personal history* can follow naturally from the account of the parental family. The clinician finds out if the patient thought he was a wanted child, avoiding the pitfalls of asking about breast-feeding and toilet-training when the patient is both in the dark about these early circumstances and also mystified regarding their relevance to his present distress. The clinician will naturally want to know whether the patient acquired control of his sphincters at the usual age, whether he bit his nails, and stopped using temper tantrums as a means of attempted mastery of the household — but these crucial facts are seldom elicited by blunt questions. To grasp in addition whether the patient separated from his mother without difficulty and managed to start his school attendance without anxiety, whether he had an early conduct disorder like stealing, or an early neurotic illness such as a childhood obsessional state, calls for an ability on the part of the clinician to empathize with the patient, and to achieve this so accurately that the patient realizes the level of perceptiveness obtaining.

One then discovers from the patient about the onset of puberty, the development of his sexual awareness and information, and the form of his erotic imagery. He conveys whether he had a chum, a first close friendship. His progress at school is studied. The course of his adolescence discloses whether he was able to separate off gradually as an independent individual from his parents, and whether this social growth — if it occurred appropriately — was relatively untroubled, or took the form of a disruptive rebellion. Identity-formation proceeds rapidly from the middle teens, and if arrested the youngster does not arrive at an understanding of his personal potentiality, nor a decision about the work he is fit for, nor a definition of the values he wants to advance. He may be greatly troubled about sexual aspects of this stage of maturation, with prolonged and recurrent fears about homosexuality or masculine inferiority. The girl may reject aspects of femininity. In the later teens the capacity for close relation with another person begins to develop if personal maturation is sufficiently orderly, the individual finding greater purpose when in intimate association with somebody else.

The clinician then inquires about courtship, marriage and the patient's own children. He completes the account of the personal history by following the jobs the patient has had during the course of his working life.

6. *Previous Illnesses* are then studied. Physical illnesses are described more readily by the patient. One is not so closely associated with one's body as with one's psychological state, therefore past somatic disorders and hospitalization can be rapidly surveyed. (They are often not accurately remembered). Physical disorders, quite apart from their somatic expression, can of course have emotional consequences, especially if they occurred early in life or left a handicap which interfered with the patient's social participation.

Previous psychological disorders are sometimes more difficult to track down. They are often revealed if careful questioning is directed to the major stressful epochs in the biography; the start of schooling, puberty, later adolescence, courtship, marriage, and the onset of middle life when youthful perspectives have outrun their applicability. The past psychiatric disorders and the way they were managed are recorded in order of occurrence.

7. The previous personality is especially important when the patient has a serious illness, a psychosis. The onset of psychosis may constitute a break with the patient's former self. Suddenly, out of the blue, the delusion took form; the cheerful, busy man altered to become anxiously preoccupied and troubled by convictions that he suffered from cancer.

The previous personality is important not only to define the time of onset of illness. It is also important because from his understanding of it the clinician can identify especial strengths — perhaps obscured by the symptoms of illness — which the patient will be able to call on when recuperating: values and habits of mind, degree of initiative, friendships and other social relationships, membership of groups, clubs and organizations, and special interests.

As the patient speaks the clinician writes. His transcript of the interview may not be orderly, but were he to cast his material in systematic form he would have obtained data in each of the important sectors of the patient's biography.

The second part of this article will appear in the next issue of Res Medica.

Trial by Fire

The Chiefs being met, a hurdle or a kind of wooden gridiron is fixed about an ell from the ground, sufficiently large and strong to receive the body of a man. The candidate places himself on this couch, lying on his back, putting into his mouth a hollow cane which is to serve him in breathing; then they cover him entirely and closely with plantain leaves, observing to pierce those that are over his head so that his cane may pass through them. A fire is then kindled under him, so managed that the flame shall not reach the grate but may give enough heat to broil their ignorant victim. If he endure the whole patiently and unmoved, he is saluted as one of their Caliques.

—from a Dissertation read before the Society in 1785.