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Assessment of the Psychological State

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Abstract

THE MENTAL STATE

Numerous of the clinical signs characterizing the mental state of the patient will have become apparent during history taking. The clinician then has the opportunity to study any aspect of the psychological state which calls for special further evaluation.

1. *General appearance and behaviour:* The patient is described tersely but vividly, to provide a record which will suffice to call him to mind as he looked when in the examination room : his posture, his expression, his clothes, his mannerisms, his reactions to the clinician, and his mode of presenting himself. In the case of a mute or stuporose patient this aspect of the mental state may be among the most revealing.
2. *Thought processes:* Talk is externalized thought, thus the clinician notes how ideas are handled and the manner in which the patient arranges and expresses his concepts. The major pathology may be in this psychological sector, and be disclosed in disordered syntax : as when a schizophrenic patient juxtaposes apparently unrelated references to a portion of his body and the river he lived close to as a child : "This is my arm and the Couch is in Essex" .

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ASSESSMENT OF THE PSYCHOLOGICAL STATE

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3. *Sample of Talk*: A segment of conversation is written down, in the patient's own words, to convey in precise context his major preoccupations.

4. *Mood*: The clinician has already obtained much evidence about the prevailing affect before he asks the patient, "How do you feel in yourself?" or "What is your mood like?" The patient may then state in dispirited tones that nothing that takes place means anything any more — "it's all flat". In some instances sadness is not mentioned directly; instead the patient talks of a dead sensation in his chest or a heaviness in his head, or the deeply pessimistic patient describes the surrounding world as grim and hopeless.

5. *Delusions*: The patient may disclose that he has developed false beliefs, misinterpreting everyday events as specially significant or attributing unwarranted intentions to people with whom he comes into contact. They are seen as intensely concerned with him, pestering him or maligning him or scorning him. He may not arraign particular people. "I know from the way I've been feeling that there is some evil force that is directed onto me by supernatural powers".

6. *Hallucinations*: When a patient perceives

sensations — visual, auditory, tactile, and so on — in the absence of any actual external stimulus, he may readily tell the examiner about them, or he may conceal the mental experiences which he himself has found startling.

“During the morning of the 10th of March, I was de-frosting my refrigerator when I distinctly heard my husband in his office, which is completely away from our house in an entirely different street. I heard him having consultations with three different people, then dictating letters and talking to his secretary. It seemed to me that I was actually hearing what was happening at that precise moment. I became rather alarmed when by lunch time the voices of all the members of my family were distinctly audible and almost incessantly present. During the early afternoon I was most disturbed to hear a strange male voice which was loud and clear. I got absolutely no peace from this voice which was accompanied by music, and a mixed choir which had the quality of what I would call Church music. After the evening meal was over this became so loud and persistent that I felt anyone in the room with me could not fail to hear it. Therefore I escaped by myself on every possible occasion: my husband became very curious about the reasons for my frequent disappearances, and in the end, I took him into my confidence.”

7. *Obsessions*: These are thoughts — ideas or images — which the patient regards as foreign and tries to dispel, but which nevertheless persist:

“The idea keeps coming back that I may be pregnant. I can’t be quite certain. I’ve never had intercourse, and my periods never stopped, so with my logical mind I know it’s impossible. I think over and over again that I may be having a child. I’ve sent away to an agency for a pregnancy test, and I saved up for an abortion.”

Compulsions are repetitive actions, the counterpart of obsessions in overt behaviour.

Abnormalities are found in the remaining psychological sectors when there is either acute or chronic brain impairment, leading respectively to temporary or permanent intellectual defect.

8. *Orientation*: An estimation of the patient’s capacity to orient himself in time and space emerges as the history is taken, and more accurate assessment is gained by testing the patient. The following five questions can be used as a test, a score of 1 point given for each correct answer:

1. What year is this?
2. What month is this?
3. What day of the month is this?
4. What is the place you are in now?
5. In what town is it?

9. *Memory* is tested by assessing the patient’s ability to recall remote and specially recent events. The clinician may already have noted gaps or inconsistencies in the patient’s account of himself. An unimaginative but effective question is to ask what he had for breakfast.

10. *Attention and Concentration* are attributes of a normal person whose sensorium is lucid. In delirium, for example, normal alertness and attentiveness are lacking. The patient cannot calculate an arithmetical sum correctly: asking him to subtract seven from 100 is a classical test.

11. *General information* is tested by asking the patient questions such as the following: Who is on the throne? Who ruled before? Who is the Prime Minister?

12. *Intelligence* is assessed from the detail and subtlety of the patient’s account of himself, his capacity to reason, and the extent of his knowledge. Accurate measurement is made by use of standardized intelligence tests.

13. *Insight and Judgement* is the final sector in the examination, and deals with the extent of the patient’s recognition that he is ill, his grasp of the nature of the disorder, and the realism of his judgement about his future.

DIAGNOSING THE PERSONALITY

The personality may be defined as the sum total of a person’s actions and reactions. Abnormalities of personality are expressed particularly in the individual’s relationships with other people. Personal relationships are differ-

ent from usual — in specific ways — when the personality is disordered.

The clinician diagnoses the personality by two clinical techniques. The first is applied during the history-taking. At the same time as he gathers the facts about the illness, he listens to gather the characteristic and repetitive behaviours which the patient describes, e.g. A man may give repeated instances of gross and passive dependence, first on his mother and later on a teacher, an employer, his wife, etc. The clinician registers mentally, as he notes down these specimens of the patient's social responses, that a morbid pattern of passivity and clinging appears to be emerging.

The second procedure depends on the use by the clinician of his own personality as an instrument in the clinical interaction. The clinician knows — or should know unless inadequately trained in interviewing — what effect he has on people, i.e. what behaviour he evokes from them. The clinician knows from experience which reactions to him are exceptional, as when a patient becomes unduly aggressive, or tends to be aloof and detached, etc. If now the passive patient mentioned above begins to stimulate the clinician into feeling that excessive demands are being made of him, that the patient will become a burden on him, a dead weight, the tentative personality diagnosis suggested by the patient's own account will have been supported, and the mode of relating characterized which impairs the patient's adjustment. The doctor has observed his own responses to the patient, and used these as clinical information. The patient may have asked for special tonics, may indulge in special pleading for another appointment in the very near future, may comment on the extent of his reliance on the doctor to take good care of him, etc.

A third possible step to confirm these two sources of clinical information about the personality structure is to request formal personality testing, to be carried out by a clinical psychologist colleague.

derived from the patient, decides on the relative weighting he will give to the different elements in the case, and arrives at a diagnosis. In psychiatry this consists of two parts:

(i) *The naming of the disorder (or nosological diagnosis):* the term to be applied to the illness depends on the most prominent symptoms and signs in the case, constituting one of the syndromes or disease patterns which can be found described in standard psychiatric texts. e.g. Depressed mood, suicidal impulses, loss of appetite, retardation of thinking, physical apathy, self-reproach and insomnia point to endogenous depressive psychosis.

(ii) *The psychodynamic formulation:* the second part of a psychiatric diagnosis lists, in a coherent sequence, the pattern of factors which the clinician considers to have contributed to bring about the illness, e.g. "The patient, the submissive member of an identical twin pair, is less attractive than her sister; during childhood her mother discriminated against her, and the patient is now resentful and hostile. She tried to suppress these impulses in order to win affection from those to whom she forms over-dependent attachments (e.g. twin sister, husband). Her illness began when she found evidence in her husband's wallet that he was associating with another woman."

Because in successive examinations the patient may communicate fresh biographical material, the psychodynamic formulation becomes gradually fuller as confirmation is obtained for particular dynamic factors in the patient's adaptive pattern. (The nosological diagnosis may also in some cases have to be revised.) The formulation of the illness can well be tested — in many cases — by communicating it to the patient (in words he can grasp), and the patient himself can then inform the clinician how aptly he is succeeding in grasping the manifest and the latent clinical facts in the patient's case.

The first part of this article appeared in the last edition of Res Medica.

THE DIAGNOSTIC FORMULATION

The fourth part of the psychiatric examination is a technical decision-making procedure. The doctor co-ordinates all the data he has