

# Interviewing Psychiatric Patients

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The patient interview provides the gateway to the health of the patient. Because it is both a science and an art, the skill of interviewing will improve as you continue your training. Although psychiatric patients differ in some ways from medical and surgical patients, what you read here will apply to nearly every patient you meet.

## Getting Started

When I was in training, students bore the honorific title of *Doctor*, but everyone, including the patients, knew it was a fraud. Much better to introduce yourself, “I’m Pat Marshall, a medical student.” Ask if the patient is agreeable to the interview, and point out how long you expect to take. Also mention that you’ll probably take some notes.

During introductions, show the patient where to sit. Try to sit across the corner of a desk or table from the patient—this gives you room to change the distance between you, as indicated by the patient’s need for space and comfort. (Across the full width of a desk hinders flexibility.)

Start off with a brief question that pinpoints where you’d like to go. “What caused you to come for this evaluation?” works for outpatients; the inpatient equivalent is, “Why were you admitted to the hospital?” Some clinicians like to begin with small talk, but psychiatric patients often feel too troubled to care much about ball games, traffic jams, or the weather.

Note that the two questions I’ve quoted are *open-ended*. That means, they can’t be answered “yes” or “no” and you haven’t suggested a multiple-choice answer. Open-ended questions help you establish a working relationship with your patient:

- They give the patient the greatest possible latitude in coming up with a response, so you don’t limited the scope of your information.
- They serve as bait when you are fishing for the sorts of problem you’ll need to explore.
- Because the patient does most of the talking, they allow you to assess your patient’s thought and speech patterns.
- Patients who are encouraged to talk freely tend to like the person doing the encouraging.

## Free Speech

Your open-ended invitation just to talk about the reasons for the evaluation should usher in a few moments of what I call *free speech*, when your patient can rattle on about whatever comes to mind. Most patients will respond with a few sentences, and then you’ll have to prompt for more information with more open-ended invitations, such as: “Tell me more about that” or “And then what?” Sometimes, just a nonverbal signal such as nodding your head or smiling can indicate that the patient is on the right track and you’d like to hear more. During free speech, you should be looking for hints that your patient has a problem in one or more of these areas:

**Mood disorders** (abnormally high or low mood) include such symptoms as affect that is depressed or flat (or too high and bubbly), loss of interest in usual activities, reduced (or

increased) activity level, changes in appetite or sleep patterns, crying, speech that is slowed or speeded up, feeling worthless, and death wishes or thoughts of suicide.

**Anxiety disorders** can be indicated by complaints of nervousness, excessive worry, panic, unreasonable fears, obsessional thinking or compulsive behavior, a history of severe emotional or physical trauma, physical complaints such as palpitations of the heart or irregular heartbeat, sweating, trembling, trouble breathing, and dizziness.

**Psychosis** may be suggested by delusions, hallucinations in any of the senses, bizarre behavior, speech that is incoherent or hard to follow, flat or inappropriate affect, fantasies or illogical ideas, social withdrawal, and impaired insight or judgment.

**Difficulty thinking (cognitive disorders)** includes defects of memory, delusions, hallucinations, fluctuating affect, bizarre or unpredictable behavior, and poor judgment.

**Physical complaints** can be signaled by increased or decreased appetite or weight, convulsions, headache, weakness, neurological complaints, and pain that can occur in one or more of many locations throughout the body. Also watch for a medical or mental history that is vague or complicated, a history of sexual abuse, and repeated treatment failures.

**Social or personality problems** may be suggested by repeated marital conflicts, legal difficulties, peculiar or bizarre behavior, a presentation that is overly dramatic or ingratiating (or grumpy), or by job problems: being fired, demoted, repeatedly tardy.

**Substance misuse** includes indicators such as use of more alcohol than two drinks a day, financial or legal problems, health consequences of use (cirrhosis, blackouts, abdominal pain, vomiting) and social consequences such as fights, marital problems, and loss of friends.

Each of these areas comprises a variety of disorders that have symptoms in common. Later on, you'll gather details about each area your patient mentions. After moments to minutes of letting your patient talk freely, you'll sense that you've obtained a broad outline of what's uppermost in your patient's mind. Then, after asking, "Are there any other important problems we haven't mentioned?" move on to explore in depth the problem areas you've identified.

## Rapport

Before *we* move on, let's consider the relationship you're trying to establish. *Rapport*, the sense of mutual trust and understanding that helps people work together, is the second of two basic goals you hope to score during your initial interview (clinical information is the first). Most patients will expect to like you, but don't coast on this expectation; take steps to build good will:

- Watch your patient's demeanor. If it's depressed, you will naturally feel like moving a little closer for support. If angry or hostile (or euphoric), you'll want to back off to give each of you more personal space. (Here's where your seating arrangements shines.)
- Monitor your own demeanor. Maintain eye contact and nod your head to show that you are listening. Patients who perceive that you like and respect them will return the favor.
- Speak plainly (professional jargon can be *really* confusing) and with compassion. You may be tempted to say, "I know how you feel..." but try not to. Unless you've suffered the loss of a loved one, been divorced, or experienced the countless disasters that patients bring, your words can come across as hollow. You might do better to express interest and

compassion: “I’ve never experienced [that situation], so I can only imagine how horrible you feel.” “I can see that it upset you terribly.” “You must have felt miserable.”

- If ethnicity or regional dialect makes it hard to understand your patient’s speech, remember that the patient may find *you* hard to follow, too. Acknowledge that you have different accents and point out that either of you may have to ask for a repetition at times.
- Follow up on material that is obviously important to the patient. That may seem hard to do early in training, when just thinking up the next question is an effort. But if instead you strive for a relaxed conversation that *won’t* yield everything you want to know, both of you may have a more productive experience. You can always return to the patient later for details that you overlooked the first time.
- Of course, your own feelings can heavily influence rapport. Try to understand any objectionable behavior or attitudes in terms of the psychological problems you are evaluating. If you focus on the patient’s feelings, rather than words or behavior, you might avert your own negative feelings. For example:

PATIENT: I don’t care about women. I’d like to see every one of them burn in hell.

INTERVIEWER: Sounds like you’re awfully angry. Have you had some bad experiences?

PATIENT: Well, let me tell you. You got a few hours?

This patient then went on to talk about his overbearing mother and how each of his two wives had abandoned him.

- On the positive side, you can offer praise when your patient does something especially well. Almost anything will do:  
“You’ve really given me a good overview of your problem. I think we can move on to some other information, now.”  
“That’s about the best ‘serial sevens’ I’ve heard this week!”

When you do offer praise for performance, make sure that it is both accurate and heartfelt. Psychiatric patients are often keen at detecting BS, and if you are insincere, it can not only poison your interview but imperil your chances at a solid future relationship.

## Boundaries

The doctor–patient relationship has changed since I was a student. Then, the doctor was often an authoritarian lawgiver who decided *for* the patient; now, many of us prefer the less formal role of collaborators who explore issues *with* the patient. The latter style is more comfortable and it encourages patients to participate in treatment decisions. It puts two minds to work, rather than loading all the responsibility onto the clinician. Patients who contribute to the management plan adhere better to treatment and complain less about bumps in the road to improvement.

Yet, even clinicians who encourage friendly collaboration must maintain boundaries. I find I can maximize personal dignity and better maintain distance by using a patient’s title and last name—Miss, Mrs., Ms., Mr. Jackson. I realize that this is not the universal practice among clinicians, but it can serve students well: it is unseemly for students and other young ward personnel to address (sometimes elderly) patients by their first names.

The first step in maintaining boundaries is to know where they are. The overarching principle is to focus on the patient's interests and needs, not on your own. It's generally safest not to reveal too much about yourself to your patients, especially during the initial interview.

A resident confided to his new patient that he was a reserve peace officer. He later discovered that the patient had a severe personality disorder and hated the police.

With this caveat in mind, sometimes you can encourage cooperation by identifying something that you and the patient share. If you attended the same high school, that coincidence might nudge you in the direction of rapport. However, to avoid excessive familiarity, use this technique sparingly, seldom more than once with a given patient. And I'd scrupulously avoid extending it to politics or religion—even offhand remarks have a way of getting around, and you never know when someone else will be put off by an opinion that your current patient applauds.

Of course, you don't have to answer personal questions, but you may want to do so; it depends on the patient's reason for asking—it may be simple curiosity or a desire to obtain reassurance about the clinician's competence:

PATIENT: Were you raised in this city?

INTERVIEWER: What makes you ask?

PATIENT: My mother told me to be sure to get a therapist who grew up here. She says no one else could really understand what it was like, growing up in a ghetto, and all.

INTERVIEWER: I see. Actually, I didn't grow up here, but I got most of my training here. I've lived in town for nearly 8 years, so I have a pretty good idea of what some of your experiences must have been. But I have the feeling you'll be able to tell me a lot more.

A question students hear has to do with age: "You seem so young for this kind of work—how old are you?" One way to handle personal questions, or any question, for that matter, is to counter with one of your own: "Why do you ask?" It plays for time and information that may help you decide whether to answer the question directly. (I wouldn't give a direct answer about age, which really isn't any of the patient's business; instead, I'd probably thank the patient for the compliment and with a big smile say something like, "People tell me I look young for my age" or, "My actual age might surprise you. But let's get back to *my* question, which was...")

## Managing the Early Part of Your Interview

During the early part of your interview, you want to keep your patient talking with as little intrusion as possible. Several *non-directive techniques* (they urge further speech without dictating its content) can facilitate this goal:

- Nonverbal encouragements. Experienced interviewers instinctively use several subtle, nearly invisible methods: they maintain nearly continuous eye contact, smile or nod for appropriate responses, and lean in a little closer to show interest.
- (Barely) verbal encouragements. Sometimes, just a syllable or two—"Yes" or "Mm-hmm"—can indicate that you understand and that the patient should just keep talking.
- Perhaps the most straightforward encouragement is a simple, direct request, such as "Please explain what you mean" or "Tell me more about that."

- Repeat your patient’s own last word to request more in the same line of thought.  
 PATIENT: ...and during the last few weeks, I’ve thought a lot about death.  
 INTERVIEWER: Death?  
 PATIENT: Well, Dad died, and I felt so frightened. I’ve got so much living to do...
- Reach back to a phrase or idea that wasn’t the patient’s last-spoken thought: “Earlier, you said that you’d thought a lot about death. What did you have in mind?”
- Just re-request the information.  
 INTERVIEWER: Can you tell me about your drinking?  
 PATIENT: Now, my dad, *he* was a heavy drinker!  
 INTERVIEWER: Yes, and how about *your* drinking?

From time to time, briefly summarize what’s been said, just to make sure you and your patient are on the same page. “So, as I understand it, you were doing pretty well until 8 or 10 months ago, when you lost your job, your wife left, and then you started drinking. Is that right?”

## Offering Reassurance

Reassurance is whatever you do to increase your patient’s confidence or sense of well-being; it also promotes rapport. Smiles and nods are fine, but mostly, we reassure by what we say. To be truly supportive, reassurance must be sincere, factual, and specific to the situation. If used too often, it can seem forced or false. You must avoid false generalizations based on insufficient knowledge, such as “I wouldn’t worry about that” or “I’m sure it will all work out just fine.” (Many patients will grumble that, in your place, they wouldn’t worry, either.) And because you obviously can’t peer into the future, your words will seem hollow and reduce your credibility.

You can reassure with praise, but only offer it when it’s deserved: “I think you handled your boss with tact and sensitivity. I can see why you are valued in your company.”

## Gathering the Database

### History of the present illness

Once you’ve identified some of the major problem areas you need to explore, start exploring! This means learning all you can about the current episode of illness—how it began, its symptoms, consequences, and possible stressors. All the while, you need to watch for hints of new territory that you also will need to cover.

Learn as much as possible about your patient’s symptoms. Are they constant or do they come and go? If episodic, how often do they occur and with what intensity? Has the intensity or frequency changed recently? Are the symptoms associated with any factor such as time of day or type of activity? For example, you can characterize auditory hallucinations as to their content (noises, mumbled speech, isolated words, complete sentences), location (inside the patient’s head, in the air, outside the room), and intensity (distant whispers to loud screams).

## **Vegetative symptoms**

*Vegetative symptoms*, an ancient term that refers to body functions involved with preserving health and vigor, are common; always look for evidence of change from prior functioning in:

Sleep. Many patients complain of insomnia. Learn where in the sleep period it typically occurs—terminal (or late, *usually associated with severe depression or melancholia*); interval, in which patients awaken during the night (*especially found in heavy drinkers and those who have PTSD*); early (*experienced from time to time by normal adults who have problems of living*). Some patients sleep too much when they are ill (*especially true of depression in younger people*).

Appetite and weight. Was weight change intentional? If your patient hasn't weighed recently, try to judge by how closely clothing seems to fit. *Classically, appetite and weight decrease with severe depression, but they increase even in some patients with mood disorder.*

Energy level. Is constant fatigue a change? Has it interfered with normal activities?

Daily mood variation. How people feel can vary with time of day. Some depressed patients feel worse upon arising but improve throughout the day; others experience the opposite pattern.

Sexual interest and performance. Interest in sex is often an early casualty of mental disorder, so explore whether your patient's frequency, ability, and enjoyment of sex have changed. *For most mental disorders, the direction will be down; for mania, libido may increase.*

## **Onset and sequence of symptoms**

Your patient may be able to tell you exactly when the symptoms began: "I started to feel depressed when my wife said she was leaving." More usually, symptoms begin gradually or the patient is vague about onset. Try to encourage precision: "Had you started to feel depressed by your birthday this year? By Christmas?" If this approach draws a blank, you might ask, "When did you last feel well?" If even this fails, explore the sequence in which your patient's problems began: "Which started first, the depression or the renewal of your drinking?" The answer could help determine the type of treatment you eventually recommend.

## **Stressors**

Some disorders seem to begin spontaneously, but you'll often identify an event that may have caused, precipitated, or worsened your patient's mental problems. From a vast range, you must judge which alleged stressors are valid. (For example, a patient claimed his depression started when he discovered fleas on his dog.) If you haven't heard about any possible stressors, ask: "Was something going on that might have started your symptoms?" Possibilities include issues at work, at home, with spouse or friends, legal problems, illnesses, and anniversary reactions.

Try to learn why your patient appears for evaluation *now*. Sometimes it's obvious—acute intoxication or a suicide attempt—but an outpatient may have come in at the behest of concerned relatives, in fear of job loss, or out of concern about worsening symptoms.

## **Consequences of illness**

The effect of mental disorder on human interactions can help you judge its severity; sometimes (as with antisocial personality and substance use disorders) it can even determine the diagnosis. You'll therefore want to learn what the effect of symptoms has been in these areas:

Marital and love relationships. Has there been serious discord, even separation or divorce?

Interpersonal. Has the patient avoided or fought with friends, been shunned by relatives?

Legal. Ask: “Have you ever had any police or legal difficulties?” Follow up positive answers with “Have you ever been arrested? How many times?” “Have you been in jail? For a total of how long?” And of course, “What were the charges?”

Employment. Has your patient missed work, quit a job, or been fired as a result of illness?

Disability compensation. Chronic illness may trigger benefits from the Social Security Administration, Department of Veterans Affairs, state compensation board, or private insurance.

Personal interests. Seriously ill patients typically lose interest in sex, hobbies, reading, TV.

## Previous episodes

You’ll need to learn details of prior episodes: When did they occur? What were the symptoms? The diagnosis? What were the social consequences? If hospitalized, how many times and for how long? What treatments were tried? Which worked best? Was recovery complete? For how long? Was there a period of time that the patient remained well without prophylactic treatment?

For previous medications, besides such basic information as name, dose, frequency, duration of use, and effects (both wanted and unwanted), learn how well the patient cooperated with treatment. People often resist admitting to poor compliance, so ask: “Have you ever had trouble following your doctor’s advice?” “What sort of difficulty have you had?”

## Suicide and Other Violent Behaviors

*Every* patient requires an evaluation of suicide potential. Some beginning interviewers worry that they’ll suggest suicide to a patient, but anyone with a potential for self-harm will have already considered it; the real risk is in asking too late. You can gently approach the issue: “Have you ever had desperate thoughts, such as wanting to be dead?” Pursue positive replies with questions about thoughts of self-harm, plans, and past suicide attempts. (Beware a “no” answer attended by hesitation, shifting gaze, or tears—each suggests that the answer may be less than candid.) You could comment, “You seem so uncomfortable, I hate to pursue this subject, but I feel I must.”

Facts about past suicide attempts help predict further attempts. You must assess both the physical and psychological seriousness of any previous attempt. A *physically serious attempt* is one that could result in significant bodily harm, such as swallowing a potentially lethal drug dose, severing an artery or large vein, inducing a deep coma, or inflicting a gunshot wound to the abdomen. At the other extreme are attempts that suggest the patient had something in mind other than dying—“gestures” such as a lightly scratched wrist or swallowing 4 or 5 aspirin.

A *psychologically serious attempt* is one where death seems clearly intended—the patient took pains to avoid discovery or greets survival with regret: “I’m sorry it didn’t work” or “I’ll try again.” Psychologically less serious attempts are those that are made impulsively, perhaps when someone else was with the patient, or when the patient admits, “I’m glad I didn’t succeed.”

Respond to suicide behavior that is either physically or psychologically serious with speed and vigor. *Avoiding suicide and other harm is a duty of clinicians, but so is maintaining confidences. If you perceive any danger to or from your patient, immediately notify your supervisor. At another time, you’ll explore the legal aspects of medicine in Oregon.*

Explore any risk of violence. A history of domestic quarrels or legal difficulties can ease you in to this line of questioning. Otherwise, you'll need to ask whether the patient has ever been involved in fights, harmed others, or been concerned about controlling impulses.

All health care personnel must ensure their own personal safety when talking with patients—being the target of a threat or assault is worse than no fun, trust me. So:

1. Provide an unobstructed exit from your interview room (two doors, or put yourself closer to the door than is the patient).
2. The room should have an alarm or someone should be within earshot of a call for help.
3. Be especially wary of any patient who has a history of violence or who should be taking antipsychotic medication, but isn't.
4. Watch for indicators of potential violence in the patient's voice (rising tempo or pitch), words (threats or insults), and body language (agitation, clenched fists).
5. If you sense danger, announce that you are leaving the room (the announcement is to avoid startling the patient), then do so.
6. Then get help at once.

## **Substance Misuse**

Substance misuse is so common (about 8% of adult Americans, 25% of adults with psychiatric illness) that you must always consider it, even in teens and senior citizens. To normalize drinking of alcohol, thereby reducing the patient's impulse to conceal it, assume that everyone drinks some and ask: "In an average month, on how many days do you have at least one drink of alcohol?" Then ask "On a typical drinking day, how many drinks do you have?" I worry about anyone who consumes more than 60 drinks per month. (The following drinks have roughly the same alcohol content: a 12-ounce beer, a 6-ounce glass of wine and a 1-ounce shot of 80-proof hard liquor.) Don't be put off by someone who says, "I don't touch alcohol." That could mean, "I haven't had a drink since Saturday night." Although the amount a person drinks is an important indicator, alcohol dependence, which we used to call alcoholism, is defined by its consequences. For alcohol or drug use, you'll need to explore the following areas:

Loss of control. Drinking more than the patient intends, setting rules about when to drink, gulping drinks, being unable to stop after the first drink

Medical. Liver trouble, vomiting spells, blackouts (amnesia for events while drinking)

Legal. Arrests, drunk driving, accidents

Interpersonal. Loss of friends, divorce, fighting, guilt feelings

Financial. Spending money on drink/drugs that should have gone to food or family support

Job. Absenteeism, being fired

Follow up positive responses with: "Have you ever been concerned about your [drinking, drug use]?" "Were you ever treated for the use of [alcohol, drugs]?" "What happened as a result of treatment?" "What's your longest period of [sobriety, being clean]?" "How did you achieve it?"

## Getting the Facts About the Present Illness

An accurate diagnosis requires *all* the relevant information. Sometimes you must explicitly state that you need the truth. (Some patients, especially teenagers, don't realize that misinformation can have serious consequences.) That's why I might say, "I understand that you hesitate to confide in me. Let's play it this way: If you feel you can't tell me the truth, just say, 'Let's skip that for now,' and we'll move on. That way, I won't get the wrong idea about you.

Studies show that open-ended questions are more likely to yield valid information, so continue to use them when you can. For example,

Instead of "Did you have insomnia with your depression?" try, "How was your sleep then?" (Some depressed patients sleep too *much*.)

Instead of "How often have you been hospitalized?" say, "Please tell me about your other hospitalizations." (You might learn about drinking episodes or suicide attempts.)

Instead of "Did your appetite change?" ask, "To what extent did your appetite change?" ("*To what extent*" can change nearly any closed-ended question into an open-ended one.)

Each symptom has its unique set of details that must be explored, but for a full, rich exploration of any behavior or event, certain items of information are always necessary. They include accurate details about these aspects of your patient's symptoms:

Type	Duration
Severity	Context in which they occur
Frequency	

This exploration will require the use both of closed-ended and open-ended questions:

INTERVIEWER: When did you first notice these episodes of anxiety? [Closed-ended]

PATIENT: It must have been about 2 months ago—I had just started my new job.

INTERVIEWER: Please describe an episode for me? [Open-ended]

PATIENT: For no reason, I start to feel nervous. Then I can't breathe. It's awfully scary.

INTERVIEWER: How often have these attacks occurred? [Closed-ended]

PATIENT: I'm not sure—it's been getting more frequent.

INTERVIEWER: Several times a day, once a week? [Closed-ended, multiple-choice]

PATIENT: About once or twice a day now, I suppose.

INTERVIEWER: What do you do about it? [Open-ended]

PATIENT: I'm too shaky to stand, so I just sit down. In 15 minutes or so, it starts to go away.

INTERVIEWER: What sort of help have you sought before? [Open-ended]

### A few rules

For the sake of completeness, I'll mention a few other obvious rules of interviewing:

- Use language the patient understands. “Sleeping with” for “having sex” is commonplace; other terms may not be, so you might have to use your patient’s street terms for sexual acts and body functions.
- Don’t phrase questions in the negative—it telegraphs the expected answer. “You haven’t been drinking heavily, have you?” essentially demands the answer, “Heck, no.”
- Avoid leading questions. Like negative questions, leading questions hint at the answer expected; judges on TV crime shows overrule them, and so should you. Instead of “Has drinking ever caused serious problems, such as missing work?” ask “Have you ever missed work because of drinking?”
- Avoid double questions. (“Have you had trouble with your sleep or appetite?”) They may seem efficient, but double questions are often confusing. Too, the patient may respond to one part of the question and ignore the other, without your realizing it.
- Encourage precision. Where appropriate, ask for dates, times, and numbers.
- Keep questions brief. Long questions with involved explanatory detail can confuse the patient; they also occupy time you could be using to listen to the patient.

## Confrontations

Confrontation doesn’t imply *angry*. It means that something needs clarification, perhaps a historical inconsistency or a contradiction between the story and how your patient seems to feel. However, try to avoid even “friendly” confrontations in an initial interview, when you don’t really know the patient well.

But when the stakes are high—let’s say your diagnosis turns on this fact—you must clear up the confusion with a confrontation. Then, use a gentle, supportive manner. “Help me understand: You just said that your father threw you out of the house, but earlier I thought you said he died years ago.” The *I thought* draws the sting of any implied criticism by suggesting that *you* might be the one who is mistaken. Here’s another way to soften the question: “When you told me what happened to your wife, I felt sad—but *you* are smiling. What else is there to this story?”

Of course, during an interview session, you should play the confrontation card sparingly.

## Interviewing about feelings

Studies show that beginning interviewers often neglect to ask about feelings—a serious omission in a mental health interview. Eliciting quality information about feelings is usually pretty easy—just ask, using techniques we’ve already discussed: direct requests and open-ended questions.

When using a direct request, be sure to mention feelings or emotions specifically. For example, if you ask, “What do you *think*...?” you might obtain only cognitive material. Instead: “How did learning about your husband’s affair make you feel?” or “What was your state of mind when you found out you’d been demoted at work?”

Open-ended questions allow the scope to sort out possibly ambivalent feelings. A person who talks at greater length is more likely to reveal true emotions. For example,

INTERVIEWER: You said you’d considered leaving your job—tell me more about that.

PATIENT: I've had a really tough time at work, what with downsizing. My boss has put me under an awful lot of stress. At times I've felt that I can't even do my job...

INTERVIEWER: (Nods without speaking)

PATIENT: But my husband points out, I could spend more time with the kids, and we could get along on less money. And I could try writing the novel I've dreamed about...

Although most patients will give you information about any emotional state you are interested in, some find it hard to talk about feelings—perhaps their relatives hid their emotions or their culture discouraged behavior that isn't "macho." Some just don't recognize their own feelings or have difficulty connecting them to their experiences (a condition called *alexithymia*); others may understand very well how they feel, but resist exposing their vulnerabilities.

Here are some other techniques for eliciting emotions:

- Express sympathy or concern. "Anyone who's had your problem would feel hurt [or angry or sad]."
- Reflection of feelings. This means, you state the emotions you think the patient might feel in a particular situation. "Your boss gave his nephew the promotion you thought you had coming? You must have been livid! And depressed."
- Picking up on emotional cues. You provide a verbal expression of the slight (often nonverbal) cues to emotional states. "When you mentioned your daughter just now, I thought you looked a bit down. What were you feeling?"
- Analogy. For a patient who cannot identify feelings, try to evoke the context of a previous experience. "Did you feel that way when your father died?"
- And always, probe for more details. "About those episodes of intense anxiety—can you tell me some more about them?" Then, keep probing until you have all the facts.

### Handling the excessively emotional patient

Emotions sometimes interfere with communication, as with people who don't understand the cause of their own feelings, for those who were reared in families where intense expression of emotion was the custom, for very anxious or depressed people, and for those who control others through intimidation. These techniques can help cap excessive verbal and behavioral output:

- Label the emotion. Just saying, "You really feel angry about this. Angry and frustrated!" conveys your understanding, which may allow the patient to turn down the heat.
- Speak quietly yourself. If your patient shouts, *lower* the volume of your own voice. Most people find it hard to yell at someone whom they must strain to hear.
- Re-explain what you want. "I know your ex-wife infuriates you, and perhaps later we can discuss that some more. Right now, I need to learn about your current relationship."
- Switch to close-ended questions.

INTERVIEWER: Can you tell me about your previous marriage?

PATIENT: It was god-awful! That bitch should rot in hell. She wouldn't even let me—

INTERVIEWER (interrupting): Did you and she have any kids?

PATIENT: Two, and they're just as bad as their mom. Always emailing and texting for—

INTERVIEWER: How long were you married?

This patient soon learned to stick to the subject.

## Personal and Social History

As important as social history can be for diagnosis and ongoing care, you should always maintain a healthy skepticism as to its accuracy: memories fade, and recall can be selective. Whenever possible, check the validity of items that seem questionable.

### Childhood and Adolescence

Ask, “Tell me about your childhood.” Beyond the bare facts (birthplace, number of siblings and birth order, parents’ occupations) you’ll want a general picture of your patient’s early life. Was this a wanted child in a close-knit nuclear family? Were there any losses from death or divorce? Did your patient have friends and enjoy hobbies and other interests outside of school? *Whereas most of these issues are unlikely to make or break a psychiatric diagnosis, they can mold personality and have a lasting effect on adult relationships.*

How far in school did the patient progress? Were there scholastic or disciplinary problems? Difficulties concentrating or sitting still in the classroom? *Childhood hyperactivity with attention deficit is common, and its effects can persist into adult life.*

Many adults will have sketchy memories of their childhood health, but you might ask about overall health status: Generally healthy? Frequent trips to the doctor? Long absences from school? *Parental “rewarding” of illness behavior with attention can precede some somatoform disorders.* Were there any of the common childhood problems: bed-wetting, nightmares or night terrors, obesity, phobias, stuttering, tics? How were they addressed, and what effect did they have on relationships with schoolmates or siblings?

When did dating begin? Did any sexual issues begin about this time? Be alert for indications of sexual or physical abuse. Still relatively taboo in everyday conversation, sex information must be actively pursued in a psychiatric interview. You can ease into the subject of abuse by asking, “Did you ever feel mistreated as a child?” and then request follow-up information, such as type, frequency, source of the abuse and parents’ reactions to it. *A significant minority of psychiatric patients have suffered childhood sexual or physical abuse, which can stand as a precursor to somatization disorder, dissociation, PTSD, and personality disorders, among others.*

### Adult life

You’ll want to know about work history (number and type of jobs, job satisfaction). Have there been periods of unemployment? If so, what was the source of support then? *Frequent job changes are typical of antisocial personality disorder; prolonged unemployment can be found in severe mood disorders and in schizophrenia.* For women and men, ask about military service: dates, duration, disciplinary problems, and rank at discharge. *If the patient saw combat, you’ll need detailed information to evaluate the possibility of posttraumatic stress disorder.*

Does your patient now live alone or with someone? In an apartment or house? Has your patient ever been homeless? What is the current financial situation? You can ask, “Has money been a problem for you?” Ask about leisure activities. Are they pursued alone or with others?

How religious is your patient? Has this changed from childhood? Also try to learn something of your patient's social support network—the number and quality of relationships with family and friends. *Support issues can help assess your patient's chances for response to treatment.*

Nowadays when we enquire about marital state, we implicitly include relationships with partners of either gender, regardless of legal status. You could start by asking, “Tell me about your partner.” Assess strong and weak points in this relationship, as well as information about past marriages and divorces. How long has the couple been together? What are their relative ages? What have the problems been? How have the patient's current mental problems affected the relationship, and vice-versa? *For many patients, there is no definable mental disorder, rather two people with mutual problems of living.* You'll also need to know about children from this relationship, as well as those of previous ones.

Although you can put off asking about sex to a subsequent interview, when you know the patient better, you might forget. Better to bite the bullet and start right in. “Could you tell me about your sexual functioning?” is a good way to start. If the response is, “What do you mean?” you can say: “I'm trying to find out how your sexual functioning is usually, and how it's been affected by [the presenting problem].” You'll also want to learn something about early sexual experiences (age and nature, patient's reaction to them), sexual orientation as an adult and level of comfort with that orientation. If your patient is in a committed relationship, be alert for some of the problems that typically affect couples: impotence, dyspareunia, premature (or delayed) ejaculation, infidelity, STDs, and concerns about possible homosexuality or bisexuality.

Finally, don't forget legal difficulties. Has the patient ever been arrested? When, and what were the circumstances? What was the resolution? For obvious reasons, people seldom raise these issues spontaneously, so you'll have to ask. *Legal history can tip you off to personality disorder (especially antisocial) as well as bipolar disorder and substance use issues.*

Ask for a self-appraisal of the patient's own personality (“Describe yourself for me.”) If this yields a blank stare, elaborate with, “What do you like best [like least] about yourself?” This fishing expedition could net information that will help you assess self-esteem and characteristics that may have smoothed (or hindered) your patient's path through life. Ask about relationships with others and examples of how the person typically copes with stressful situations. Some other possible questions: “What sort of situations do people think you have trouble handling?” “How well do you control your temper?” “Is there anyone—any type of person—you can't stand?”

Of course, people may paint too rosy [or gloomy] a personal assessment of personality. A fuller picture requires information from significant others and previous clinicians, but your rough assessment could highlight some of the issues that you need to consider in treating this patient.

## Medical History

To be sure, you would pursue the general medical history anyway—that's what doctors do. But in psychiatry, it is especially important to learn about general medical symptoms and previous diagnoses, because you will occasionally encounter a patient whose depression was caused by Lyme disease or a psychosis that was the result of an endocrine disorder. Side effects of medications can also produce a variety of mood, anxiety, and even psychotic disorders.

Consult standard texts for the specialized review of systems used to evaluate *somatization disorder*, a chronic illness that affects perhaps 8% of female psychiatric patients (rarely, in men).

## Family History

Here, you hope to learn biographical information about the patient's relationship with parents, siblings, children and, especially during childhood, any extended family. In addition, and highly pertinent to many psychiatric disorders, is any family history of psychiatric illness, which are usually familial and frequently hereditary. To ensure that your patient understands what you're after, you'll need to be explicit. I usually start with a rather long speech like this one:

"I'd like to know whether any of your blood relatives ever had a nervous or mental disorder. By 'blood relatives' I mean your parents, brothers and sisters, children, grandparents, uncles, aunts, cousins, nieces, and nephews. Has any of these people ever had nervousness, nervous breakdown, psychosis or schizophrenia, depression, problems from drug or alcohol dependence, suicide or suicide attempts, delinquency, hypochondriasis (define this term if you think the patient won't understand), mental hospitalization, or arrests or incarcerations? Any relatives who were considered odd or eccentric or who had difficult personalities?"

Move slowly enough through the disorders to give your patient time to consider. And don't accept a diagnosis of schizophrenia, just because that's what family mythology has passed along as the reason for Grandpa Jim's mental hospitalizations. Anything this serious demands that you fish around for information about symptoms and response to treatment, so you can make your own evaluation (his psychosis could have been due to bipolar disorder or alcohol dependence).

## Control of the Later Interview

By this point, you want a lot of succinct answers to specific questions; what if your patient is still talking about Grandpa Jim? You'll need to encourage brevity without impairing rapport.

- State your need to move on: "I'd like to hear about that later, if there's time. Now, let's focus on..." or "Let me interrupt here to pursue something else that's important."
- Nod or smile approval when you get the sort of brief answer you'd like.
- Make an empathic comment before changing subjects: "Your relationship with your husband sounds distressing. Have there been other problems, such as at work?"
- For a patient who continues to ramble, you may need a firm intervention: "Our time is a little short..." "Let's stick with the main topic for now..."
- By this time, you'll be using more closed-ended questions—those that can be answered "Yes" or "No" or with a specific piece of information such as a date or name—but don't completely abandon open-ended questions. They're still important for information about emotions and, because they require less work, to give you a breather.

## Transitions

Interrogations are no fun, so try to make your interview seem more like a conversation with smooth transitions between topics. You can incorporate your patient's own idea or words:

PATIENT: ...my wife's relationship with my son really improved after he got a job.

INTERVIEWER: And what about your own relationship with her? Did that improve, then, too?

Any common factor—place, time, relationship—can iron out the flow of a conversation:

PATIENT: ...it was the last time I saw my brother before he enlisted in the Army.

INTERVIEWER: And did you have any military service yourself?

If you do have to make an abrupt transition, flag it so the patient realizes you're intentionally changing direction: "I'd like to change gears, now, and ask you about..." "

Demonstrate concern for the patient's feelings, especially with highly charged questions.

- A sympathetic facial expression or tone of voice can soften any question.
- With "I realize your husband's death makes it hard to talk about him," you acknowledge your patient's distress but declare that the topic is important to pursue, anyway.
- "How would you feel if the police picked you up for drug use?" Supposition helps your patient achieve some distance from an emotionally charged situation.
- "How do you think other people would cope with a child who's had drug problems?" By asking how others would react or feel in a similar circumstance, you can reduce your patient's sense of isolation and responsibility.
- "Have you ever had the opportunity to apologize for your behavior when you were drinking?" Here, you soften the question by suggesting that chance might have prevented some praiseworthy action the patient should have taken, but didn't.

## Mental Status Exam—Observational Aspects

Your evaluation of current mental functioning is the mental status exam. About half of it you obtain by simply observing while you interview; for the balance, you'll have to ask questions.

### General appearance and behavior

Besides ethnicity, gender, and apparent age, you'll want to notice nutritional status (*does this patient look anorectic?*) and hygiene and clothing (*bizarre dress suggests psychosis, a misbuttoned shirt could mean dementia*). How alert is the patient? (*Drowsiness may be simply due to fatigue, but it could suggest a drug overdose.*) A fluctuating level of consciousness could mean delirium. And watch for hyperalertness (excessively vigilant scanning of the environment (*found in posttraumatic stress disorder and paranoid disorders*)).

Motor activity could be normal, reduced, or excessive. Overactivity could be the pacing or fidgeting of akathisia, a side effect of the older antipsychotic drugs, but an occasional, uneasy shifting of position or jiggling a leg while seated is usually simple anxiety. Carefully note any other involuntary movements, such as picking at skin or clothing (*found in delirium*). Mostly, the gestures you notice will be everyday "talking with the hands," though some will express unvoiced ideas—the circled thumb and finger OK and the not-so-OK extended middle finger. Watch for tremor (*possibly parkinsonism, more often anxiety*) or clenched fists.

Although depressed people are often underactive, true immobility is pretty rare. *It is found in catatonia, a classical feature of schizophrenia but also found in profound depression or frontal lobe dysfunction due to various medical conditions.* Note any mannerisms—the unnecessary behaviors that are a part of a goal-directed activity, such as the flourish some people make before signing their names. *Mannerisms are common and usually normal. Stereotypies are non-goal-directed behaviors such as crossing oneself without apparent purpose. A person who*

*postures* will strike and hold a pose (think Napoleon), again without apparent purpose. A patient who deliberately turns away from you may be showing *negativism*. In *waxy flexibility*, the limbs are rigid but you can slowly, with pressure, bend an elbow as if it were a soft wax rod. A patient with *catalepsy* holds an odd or unusual posture that you physically impose, even after you have said, “You can relax, now.” *Stereotypies, posturing, waxy flexibility, negativism, and catalepsy usually indicate psychosis; they are infrequently encountered today.*

Facial expression may be “normally mobile” if your patient smiles, frowns, and otherwise responds appropriately throughout your conversation. A patient who repeatedly glances around the room, as if listening to voices or noticing something you cannot see may be experiencing a psychosis. Notice your patient’s eye contact: *gaze riveted to the floor may be due to depression; a fixed stare could mean senility or psychosis.* Are there tics of eyes, mouth, or other body parts?

Does your patient’s voice have a normal lilt (called *prosody*), or is it dull and monotonous? What can you deduce about education or family background from use of grammar? Accent often identifies the country or region in which the person was reared. Does the patient lisp, mumble, stutter, or show any other evidence of speech impediment? Note any mannerisms of speech, including phrases or words used frequently. Is the tone of voice friendly, sad, hostile?

You can describe your patient’s apparent relationship to you along several continua:

Cooperative → obstructionistic

Friendly → hostile

Involved → apathetic

Open → secretive

Your rapport and the amount of information you obtain could depend in part on how far to the left your patient scores on each of these factors. Also note any evasiveness or seductiveness.

## **Mood and Affect**

Some clinicians use mood and affect interchangeably. However, many regard *mood* as meaning the way someone feels and *affect* as how that person appears to feel. By the latter definition, which we’ll use here, affect comprises not only stated mood but also eye contact, facial expression, posture, and tearfulness. We use several dimensions to describe mood (affect):

### **Type**

When you ask, as you should, “How are you feeling now?” many patients will say, “about normal” or “medium.” Others may admit to one of these basic emotions: Anger, anxiety, contempt, disgust, fear, guilt, joy, love, sadness, shame, and surprise. For people who cannot tell you how they feel (*alexithymia*), suggest some of the possibilities mentioned above. You can also infer much from body language:

Anger: clenched jaw or fists, flushed face or neck, drumming fingers, extended neck veins

Anxiety: jiggling foot, twisting fingers, affected nonchalance (such as picking one’s teeth)

Sadness: moistening of eyes, drooping shoulders, slowed movements

Shame: poor eye contact, blushing, shrugging

In evaluating depression, try to learn whether this mood differs from the grief a person feels at the loss of a loved one. Ask, “Did you feel this way when your [relative] died?”

## **Lability**

Although normal people may experience different moods within a brief time span, wide swings are often abnormal. Then we identify increased lability of affect, perhaps going from ecstasy to tears and back within moments. This could be the *microdepression* often encountered in mania or the *affective incontinence* sometimes noted in dementia.

Reduced lability of affect we call *blunted* or *flattened*. It is found in severe depression, schizophrenia, and in Parkinson’s disease and other neurological illnesses.

## **Appropriateness**

How well does your patient’s mood match the situation and content of thought? Most of us exhibit inappropriate mood from time to time, but *marked incongruity suggests disorganized schizophrenia* (e.g., laughing at the death of a parent). *Pathological affect* (inappropriate crying or laughing) sometimes occurs in pseudobulbar palsy, the result of various disorders such as multiple sclerosis and strokes. Some somatization disorder patients talk about their physical disorders with less concern than you hear on the weather report; this type of inappropriate mood is called *la belle indifférence* (French: lofty indifference).

Remain alert for signs of unexpressed emotion, but don’t overinterpret. Instead, relate what you observe to what the patient says and to how you think you yourself might feel under similar circumstances. Does the current topic warrant tears? Does your patient appear unnaturally sad? Is that smile genuine or does it seem forced, perhaps to hide true feelings?

## **Intensity**

You can grade intensity of mood as mild, moderate, or severe (think of the progression from dysthymia through major depression without—and then with—psychosis). You might also consider whether the mood is fleeting or prolonged, or somewhere in between.

Finally, there’s the absence of feeling or emotion that we commonly call *apathy*. It and its fraternal twin, *avolition* (lacking motivation or desire), are often associated with psychosis and severe depression, but in and of themselves, they are not pathological. Think spring fever.

## **Flow of Thought**

How do the patient’s thoughts move along from one to the next? (Of course, what we actually perceive is the flow of speech, from which we infer thought.) Defects include 1) association (how words are grouped to form phrases and sentences) and 2) rate and rhythm of speech. Psychiatrists often can’t agree on where to have breakfast, let alone these definitions. I’ve adopted the best consensus view, but you should illustrate *your* findings with direct quotations.

## **Association**

Does your patient speak spontaneously, or only in response to questions? If you haven’t yet had a run of free speech to evaluate the quality of your patient’s thinking, better ask: “I think I could get a better feeling for what’s bothering you if you just talk about your problems for a bit.”

In *derailment*, sometimes called *loose associations*, one idea runs into another, possibly related, one so the direction of the words seems controlled by rhymes, puns, or other rules—but not by logic you can understand. “She tells me something in one morning and out the other.” “I’ve got to put the kettle out, my taxi died.” *Flight of ideas* is a form of derailment in which one idea takes off from another, with the patient eventually losing the thread of the original question. *Mania patients often have flight of ideas and talk very rapidly (push of speech):*

INTERVIEWER: Can you tell me about your relationship with your mother?

PATIENT: Sure, in our family Mom was king, and King Kong never knocked out New York, my favorite place in the whole world. That’s d-l-r-o-w *world* backwards, which is where I never want to be, on the back wards. Get it?

*Tangentiality* (or tangential speech) is an answer that seems irrelevant to the question asked:

INTERVIEWER: Can you tell me about your relationship with your mother?

PATIENT: My golf balls got pink dimples.

A patient who answers too briefly or who sits speechless shows *poverty of speech*. When severe, muteness ensues. *Poverty of speech can be found in depression, schizophrenia, and occasionally in somatization disorder. You must distinguish it from neurological aphonia.*

A number of terms describe speech pathology you don’t often encounter in clinical interviews. Most occur classically in schizophrenia, but any may occur in psychoses of cognitive origin. When you do encounter an example, be sure to record it with a direct quotation.

- Thought blocking. The train of thought stops suddenly, before arriving at the station. The patient usually doesn’t know why, only that the thought has been “forgotten.”
- Alliteration. A phrase includes repetitions of similar sounds. Poets often use it for effect: “The street sounds to the soldiers’ tread/And out we troop to see...” (A. E. Housman)
- Clang associations. The choice of words is controlled by rhymes or other similarity of sound, rather than the requirements of communication.

INTERVIEWER: Can you tell me about your relationship with your mother?

PATIENT: Oh Mom, poor Mom. She’s calm, a damn warm dam...

- Echolalia. The patient unnecessarily repeats words or phrases. Sometimes subtle, you might not recognize it until there have been several repetitions.

INTERVIEWER: Can you tell me about your relationship with your mother?

PATIENT: Relationship with my mother. Can you tell me about your relationship? With my mother.

- Verbigeration. Without obvious purpose, the patient continues to repeat words or phrases. “It was deathly still. Deathly. Deathly still. Deathly. Still deathly.”
- Incoherence. Even individual words or phrases appear to have no logical connection: “Shovel. . . it wasn’t the. . . best hatred. . . lifetime .” Sometimes termed *word salad*.
- Neologisms. In the absence of artistic intent (such as Lewis Carroll’s *Jabberwocky*—“’Twas brillig, and the slithy toves / Did gyre and gimble in the wabe ...”)—the patient

makes up words, often from parts of dictionary words. The resulting structure may sound authentic: An Alzheimer patient spoke of “rakebucketing in the garden.”

- Perseveration. The patient repeats words or phrases or keeps returning to the same point.

INTERVIEWER: Can you tell me about your relationship with your mother?

PATIENT: Mom and I were close, real close.

INTERVIEWER: And what about your father?

PATIENT: Mom and I were buddies. Real close.

INTERVIEWER: And your father...?

PATIENT: Mom was my best friend.

- Stilted speech. Accent, phraseology, or word choice gives speech an unnatural or quaint flavor, such as an American who affects a British accent or uses British idioms.

Bottom line: Take care when evaluating your patient’s manner of speaking. Because speech patterns can be shaped by cultural or geographic influences, by neurological disorders, and the patient’s native language, what you hear may carry no pathological significance at all.

### **Rate and Rhythm of Speech**

*Push of speech* (or *pressured speech*) occurs when someone speaks rapidly, often at great length. Loud and hard to interrupt, such patients challenge your interviewing ability. There is often an associated *decreased latency of response* (the interval between your question and the patient’s answer). Both of these are typically found in mania patients, who may say that their words can’t keep pace with their thoughts. Depressed patients may have *increased latency of response*, with long pauses between words. There may be accompanying general *psychomotor retardation*.

Disorders of rhythm of speech involve abnormal timing of syllables, such as in *stuttering*. *Cluttered speech* is rapid, tangle-tongued and disorganized. Patients with cerebellar lesions may utter each syllable at such a uniform pace that the speech sounds unnatural. Muscular dystrophy may produce speech clusters or difficulty uttering syllables. Some patterns are usually normal:

- Circumstantial speech. After much irrelevant material, the person eventually comes to the point.
- Distractible speech. Extraneous sounds or motion may temporarily send the speaker’s words off in a new direction. *Though usually normal, you may note it in mania.*
- Verbal tics. We all use these time-fillers, which are almost always normal (but boring): “Y’ know” — “I go” (for “I said”) — “Basically” — “Awesome”

## **Mental Status Exam—Cognitive Aspects**

The balance of the MSE requires you to obtain answers to questions, some so basic as to seem insulting. So you should probably start with the brief explanation that you now need to ask some routine questions. The words *routine* and *normal* help soften questions that might otherwise be taken amiss. Here are some other steps you can take to motivate your patient:

- Give positive feedback when warranted. “That’s terrific, the best calculations anyone’s done for me this week.”
- Watch for any distress your questions might cause and respond appropriately. “Yeah, mentally subtracting sevens can be hard. Let’s give it a rest and try presidents, instead.”

Do the formal part of the MSE early in your acquaintance—you need the data base information, and if you put it off, you’re likely either to forget it or ignore it.

## Content of thought

This means, the focus of an individual’s thought at any given time. For most people, you’ll note that the content of thought is largely the concern that brought them for evaluation; for most outpatients it will seem pretty normal. However, psychiatric patients can have a variety of thoughts that aren’t at all normal, some of which you need to ask about.

## Delusions

A delusion is a fixed, false belief not explained by the patient’s culture. By fixed, we mean that you cannot shake the person from the idea.

INTERVIEWER: What would you say if I told you that there are no aliens, and they cannot possibly have abducted you into their space ship.

PATIENT: I’d say you were crazy.

INTERVIEWER: Could your idea be due to a nervous or mental problem?

PATIENT: No way. I was probed, all right.

If the patient agrees that your alternative explanation is possible or says “I’m just not sure,” the idea isn’t a delusion. It must also pass the cultural criterion: you wouldn’t call a traditional Navajo delusional for believing in witches, nor children who write letters to Santa Claus.

*Overvalued ideas* are held despite lack of proof of their worth. Though not obviously false, logic won’t usually dislodge them. Examples include the superiority of one’s own gender, race, or religion. Sometimes, as with racial hatred, they interfere with the individual’s functioning, causing suffering to the person or to those around.

Psychiatric patients can experience quite a variety of delusions:

**Grandeur.** The false belief is that the patient is someone of elevated rank or station (God, Paris Hilton) or has special powers or gifts (enormous wealth, eternal life). *Mania patients classically have grandiose delusions, but so do some patients with schizophrenia.*

**Guilt.** *Especially found in severe depression, sometimes in delusional disorder,* the patient has committed some grave sin or error (for which punishment may feel deserved).

**Ill health or bodily change.** A terrible disease has rotted the patient’s insides or turned bowels to cement. A delusion that the patient has died, sometimes called *nihilistic*, is an extreme case. *Occasionally found in severe depression and schizophrenia.*

**Influence (or passivity).** The patients believe they’re controlled from the outside by such influences as radio, TV, or microwaves, or that they control the environment (one patient believed her tears could spawn hurricanes). *Typically found in paranoid schizophrenia.*

Jealousy. The patient's spouse has been unfaithful—*classically encountered in alcoholic paranoia, but also in paranoid schizophrenia and paranoid disorder.*

Persecution. One of the more common types of delusion, the patient's belief is in being threatened with harm, ridiculed, or otherwise interfered with. *Paranoid schizophrenia.*

Poverty. Imminent destitution will force sale of the homestead and other property, despite money in the bank or a regular disability check. *Severe depression.*

Reference. These patients "notice" that people whisper when they pass by, that news media contain special messages for them. A patient thought that when Jim Lehrer on the Newshour said that a settlement was imminent, it meant that he should agree to the property settlement with his former wife. *Though found in other psychoses, especially common in paranoid schizophrenia.*

Thought broadcasting. The patient's thoughts are somehow transmitted, perhaps by radio waves. Similar to delusions of mind-reading. *Schizophrenia.*

Thought control. Feelings, ideas, or thoughts are put into (*thought insertion*) or withdrawn from the patient's mind. *Similar to ideas of influence, with similar diagnostic import.*

In addition to type, learn all else you can about the delusion. How long has the patient felt that way? What effect has it had on behavior? How does the patient feel about it? Why does the patient think this is happening? (I don't normally like "why" questions, which often yield little new information. Here, a "why" question might elicit elaboration of the delusion.)

Is the delusion *mood-congruent*—does the content fit the patient's mood? A severely depressed man's belief that he has gone to Hell and is being tormented by devils is mood-congruent; an angry woman who believes she is Jesus has a mood-incongruent delusion. *Mood-congruent delusions are typical of mood disorder, mood-incongruent of schizophrenia.*

## Hallucinations

Hallucinations are false sensory perceptions; that is, patients think they perceive something absent any actual related stimulus. Although hearing is the sense most commonly involved among psychiatric patients, hallucinations can involve any of the traditional five senses. Screen for hallucinations by asking, "Do you ever hear voices or other sounds when no one is around to produce them? Do you ever see things other people cannot see?"

Some patients claim auditory hallucinations when they actually hear only *your* voice or their own thoughts. Careful questioning can usually sort out these false positives. Ask: "Could [this voice] be coming from you, like your own thoughts or conscience?" A patient who admits that it could be "noises out in the hallway" or "my imagination" probably doesn't have true auditory hallucinations. You can ask, "Is the voice as clear as mine?" Again, discount "no" answers. In *audible thoughts*, the patient's own thoughts are spoken so loudly that *others* can hear.

Another confound is the *illusion*, a misinterpretation of an actual sensory stimulus. It is usually visual, occurs in dim light, and is readily acknowledged once the patient realizes the mistake. A common example: clothes thrown over a bedside chair look like an intruder. Illusions are almost always normal, though patients with delirium or dementia may report them.

Try to determine the severity of hallucinations. You can grade auditory ones, for example, on a continuum: Vague noises → mumbling → understandable words → phrases → complete sentences. I also like to know whether there is more than one voice, and if so, do they talk to one

another, perhaps commenting on the patient's behavior (these have been called "first rank" symptoms of schizophrenia)? Does the patient recognize the speaker? Where is it coming from?—The patient's head? The toaster? Next door? What is the content of the speech, and how does the patient react? If the voice issues commands, does the patient obey? This last is an important point: patients who obey command hallucinations sometimes cause injury—or worse.

You can similarly grade *visual hallucinations*: Points of light → blurred images → formed people (how big are they?) → scenes or tableaux. You can ask a lot of the same questions, suitably altered, as for auditory ones. When do they occur (only when using drugs or alcohol)? What is the content? How does the patient respond? (It can be pretty frightening—as one of my patients discovered upon looking into a mirror and noting that he had the face of a camel.)

*You'll especially encounter visual hallucinations in the cognitive psychoses. In the throes of delirium tremens when withdrawing from heavy, prolonged alcohol use, patients may see tiny people or animals. Images linger on the retina in the trailing phenomena that sometimes accompany psychedelic drug use. Schizophrenia patients can also experience visual hallucinations, early forms of which may include objects that change size or develop intense colors. Tactile hallucinations (sensations of burning, itching, or of bugs crawling on or under the skin) and olfactory hallucinations (unusual odors, often unpleasant) are likely to indicate the presence of a psychosis caused by physical illness, such as temporal lobe epilepsy.)*

A woman told me, "Early one morning I saw the *Devil* standing over my bed. I was totally awake but paralyzed—couldn't move my arms or legs! I was so frightened. Am I crazy?" Happily, I could affirm her sanity by explaining that she had experienced a combination of *hypnopompic imagery* with sleep paralysis. They both occur while awakening.

That brings up another point: Any interview can be therapeutic. Just telling one's problems to another person is a relief. Sometimes, clinicians can provide reassurance without derailing the information-gathering. Of course, students are unlikely to have this opportunity while they are still learning the ropes, but once you're in practice, you can experience the pleasure of helping another human being with the simplest of devices, the "verbal laying on of hands."

## **Anxiety Symptoms**

Fear that isn't directed at (or caused by) something the patient can pinpoint we call *anxiety*. Usually, there are also unpleasant bodily sensations, along with other mental symptoms that include irritability, trouble concentrating, worrying, and often a brisk startle response. Screen for anxiety symptoms with: "Do you feel you worry about things out of proportion to their real danger?" "Do you often feel anxious or tense?" "Do relatives or friends call you a worrywart?" Follow up by defining when the worries occur, their effect on the patient's life, and what helps.

A person who suddenly experiences intense anxiety with the rapid onset of sensations such as tachycardia, dyspnea, weakness, and sweating is having a *panic attack*. Such patients often feel they are about to die or go mad. Screen by asking: "Have you ever had a panic attack, when you suddenly felt terribly frightened or anxious?" Follow up by learning all the other symptoms the patient might have had, how long the attacks last, how often they occur, and their effect on the patient's life. Are attacks associated with *agoraphobia*, the fear of being away from home or "trapped" in a public place such as a theater or supermarket and unable to get out?

A *phobia* is any unreasonable, intense fear associated with a situation or object. *Specific phobias* include air travel, heights, closed spaces, and a zoo-full of animals. *Social phobias* include speaking or eating in public, using a public urinal, and writing (“I hate it when people see my hands shake”). Screen for phobias: “Have you ever had fears that seemed unreasonable or out of proportion, but that you just couldn’t shake?” “Have you ever been afraid to leave home alone, or of being in crowds, or in public places such as stores or on bridges?” Ask about *anticipatory anxiety*—intense, often incapacitating dread that precedes the actual event.

An *obsession* is a dominating thought, belief, or idea (they commonly involve dirt, money, or time). *Compulsions* are acts the patient performs repeatedly, often to combat an obsession, such as heeding baseless superstitions, counting things, or following rituals. Obsessions and compulsions often go together, no surprise; patients usually recognize them as senseless and often try to resist them. Screen: “Have you ever had obsessional ideas? I mean thoughts that may seem senseless to you, but keep returning anyway.” “Have you ever had compulsions—such as rituals or routines you feel you must perform over and over, even though you try to resist?”

### **Suicide and Violence (again)**

Because this topic is so important, I mention it again as a reminder. The screens: “Have you any ideas or thoughts of harming or killing yourself?” “What would it take to make suicide seem less attractive?” Regard as ominous any equivalent to the answer, “Nothing could.”

For violence: “Have you been feeling so angry or upset that you think about harming someone else?” “Have you ever had trouble resisting the urge?”

Positive answers must be followed at once and compared with the historical information you already have. Does the patient have plans? The means (guns, lethal drugs)? A timetable?

### **Consciousness and Cognition**

Here, you use approximate (but useful) clinical tests to evaluate the patient’s ability to absorb, process, and communicate information. I *never* describe these routine tasks as “silly”—that risks the question, “Then, why do them at all?” I also avoid the word “simple,” which could increase the discomfort of anyone who has trouble answering. Doing poorly on any test can be stressful, so be prepared to support the patient who stumbles: “It’s hard to do your best under pressure” or “Most people have trouble with that task.” And, always, acknowledge what the patient does well.

### **Attention and Concentration**

By now, you should have a good idea of your patient’s *attention* (the ability to focus on a topic or task) and *concentration* (the ability to sustain focus over time). We sometimes use calculations to assess these qualities. Ask the patient to subtract 7 from 100, then take 7 from the result, and so on. Most adults can finish in less than a minute with fewer than 4 mistakes, but you must take into consideration the person’s age, education, culture, and degree of depression and anxiety. I often try to get a rough idea by introducing a subtraction task in the course of my interview. For example, if my patient mentions a date years ago, I might say, “And how old would you have been then?”

If subtractions prove too hard, try a less culture-bound test: “Count backward by 1s from 87 and stop at 63.” Spelling *world* backward is asked so often that some patients can rattle it off without thinking, so you might try spelling *strap* or *watch* backward (first make sure the patient

can spell it forward). Recalling a series of 5 to 7 digits forward, then backward, depends less on education. *Reduced attention can be found in conditions such as epilepsy, dementia, head injury, schizophrenia, and bipolar disorder. Much of our mental processing depends on the ability to focus attention; if attention is impaired, interpret cautiously the rest of your MSE findings.*

## Orientation

You'll probably already know whether your patient is oriented to person, but you should test time and place. Ask "Where are we right now?" (City, state, name of facility). If you draw a blank stare, try "What sort of a building is this?" "*A museum*" or "*The World Trade Center*" suggests severe pathology, but also consider sarcasm from an angry or uncooperative patient.

"What is the date?" Lots of patients will get the year and month right but be off a day or two. Usually, this is normal, especially for a retired, older patient or a hospitalized person who doesn't have a normal routine to provide cues. If there is any confusion about place or time, evaluate orientation to person: "Would you tell me your full name again?"

Some disoriented patients try to hide their mistakes with made-up responses that sound logical. The process (*confabulation*) isn't lying, because these people seem to believe what they are saying. For example, a ward patient, asked whether he had ever met the interviewer before, said, "Oh yeah! It was last night, down in the bar." *You may encounter confabulation in thiamin-deficient patients severely impaired with amnesic disorder due to chronic alcoholism.*

## Language

*Language*, the means whereby we use words and symbols to express and understand meaning, includes comprehension, fluency, naming, repetition, reading, and writing. Its assessment is especially important in older and physically ill patients. *Hysteria, dementia, and other mental conditions are sometimes misdiagnosed when the patient actually has a disorder of language.*

- *Comprehension* should be evident from your interview. As a simple test, request this complex behavior: "Pick up this pen, put it into your pocket, then return it to the table."
- *Fluency*. Watch for hesitation, mumbling, stammering, and unusual emphasis.
- Problems with *naming* may be evident from the use of circumlocutions to describe everyday objects. A patient with a naming aphasia might call a watch band "The thing that holds it on your wrist" or a pen "A whatsis for writing."

Screen for aphasias by asking the patient to name the parts of a ball point pen: point, clip, barrel.

- Test *repetition* by ask the patient to repeat a simple phrase, such as "Tomorrow will be sunny."
- *Reading* is quickly tested by asking the patient to read a sentence or two.
- Test *writing* by asking your patient to write any sentence or one that you dictate.

Problems on any of these screening tests should prompt a neurological evaluation.

## Memory

We commonly assess immediate, intermediate, and long-term memory.

*Immediate memory* (the ability to register and reproduce information after 5 or 10 seconds) is really a matter of attention, which you've already tested with serial sevens or counting. You can assess it again on your way to testing short-term memory. Name several unrelated items (I use a name, a color, and a street address), then ask the patient to repeat these items. This repetition also provides assurance that the patient has understood you.

Should you alert patients that you plan to test them later? One school of thought advises "yes," though I don't think I've ever read the reason why. The other points out that any warning invites cognitive rehearsal, which could mean that a patient benefits from practice—and perhaps pays insufficient attention to the questions you ask in the meanwhile. I prefer not to warn, but the issue may be more cosmetic than cosmic—perhaps either method's OK, as long as you are consistent. What you want is a feeling for the range of normal response.

Five minutes later, test *short-term (recent) memory* by asking your patient to recall the three items. Most will repeat the name, color, and at least part of the address. When evaluating the results, be sure to consider your patient's apparent motivation. Failure on all three tasks suggests serious inattention due to a cognitive disorder or stress from depression, psychosis, or anxiety.

You can best assess *long-term (remote) memory* from the patient's ability to relate the history of the present illness and facility with details of marriages, births of children, and other personal information. Experts disagree about the dividing line between short-term and long-term memory, but most agree that between 12 and 18 months some sort of consolidation takes place, so that memories stored long-term are not easily forgotten. Eventually, though, patients with severe dementias such as Alzheimer's will lose even long-retained information.

You'll encounter *amnesia*, the temporary memory loss due to physical or psychological trauma, in *head trauma, alcohol blackouts, PTSD, and dissociative disorders*. It can be hard to ascertain—the natural answer to "Have you ever suffered from amnesia?" is "I don't remember." You might try: "Have there been periods of time that you cannot remember at all?" "Have others ever noticed that you have trouble with your memory?"

Try to determine whether amnesia is *fragmentary* (the patient can remember isolated bits) or *en bloc* (complete loss of memory for that time). You might try to bracket the memory hole with the memories on either side ("What's the last thing you can recall just before the period of amnesia; what's the first thing you can recall afterwards?"). You could also ask, "Have friends or relatives tried to help you reconstruct what happened?" *Don't assume that a memory hole means something bad happened—clinicians have come to grief persuading patients that amnesia implies assault or molestation, the notorious false memory syndrome.*

## **Cultural Information**

These tasks mainly assess the patient's remote memory and general intelligence, so some texts don't even mention them. They are, however, a traditional part of the mental status exam:

"Who is president now? Who was just before?" Most patients can name four or five presidents, working backward. If one is omitted, it's fair to try to jog your patient's memory. "Let's see, did you leave out anyone?" or, "He's hiding between two Bushes."

Other cultural tests are to name the governor of the state, five large cities, or five rivers.

You can also get a pretty good idea of your patient's intelligence, memory, and interests by asking about current sports events, candidates in the next election, and other cultural items.

## Abstract Thinking

The ability to abstract a principle from a specific example is another traditional task that depends heavily on culture, intelligence, and education. Commonly used abstractions include proverbs, similarities, and differences.

“What does it mean when someone says that people who live in glass houses shouldn’t throw stones?” “Can you tell me what this means—A rolling stone gathers no moss?” Note that some proverbs have more than one interpretation (moss-gathering could be judged as either desirable or not). Accept any logical interpretation.

Similarities and differences are somewhat less culturally bound than proverbs, so you are probably better off asking some of these: “How are an apple and an orange alike?” (Both are fruit, spherical, have seeds.) “How do a child and a dwarf differ?” (A child will grow.)

## Insight and Judgment

*Insight* refers to your patient’s ideas about what is wrong. It may be evident, but you can ask:

“Do you think there is something wrong with you?”

“What kind of illnesses do people come here to get treated for?”

“What are some of your strengths?”

“Do you think you are impaired in any way?”

Insight may be full, partial, or nil—a mania patient with partial insight might realize that something is wrong but blame others for it. Insight also tends to deteriorate with worsening illness and to improve during remission. *Poor insight is typical of cognitive disorders, severe depression, and any of the psychoses.*

Patients’ assessment of their own strengths—what they think they are good at—can be important for recommending treatment and estimating prognosis. Evaluate your patient’s self-image with: “What do you like about yourself?” “How do you think others people see you?”

*Judgment* is the ability to determine an appropriate course of action to achieve realistic goals. Some writers still recommend assessing judgment with hypothetical questions such as “What would you do if you found a letter with a stamp on it?” or “How would you react if a fire broke out in a crowded theater?” I avoid such questions, which probably have little bearing on real patients in the real world. In the final analysis, your best appraisal of judgment may come from the history you have just obtained. Or ask: “Do you think you need treatment?” “What do you expect from treatment?” “What are your plans for the future?”

## When Can You Omit the MSE?

Because you derive much of the MSE by observation alone, the real answer is “Never”. What I’m really asking is, Can a clinician safely avoid asking the questions contained in the cognitive portion of the mental status exam? For students, the answer is “No,” because you should be learning what to ask and what answers to expect from normal (and abnormal) people. But an experienced clinician will sometimes omit the formal questioning when faced with an outpatient who presents a well-organized history or when the results of formal testing are available.