ORIGINAL ARTICLE

ENCHANT - Enhancing Psychiatric History Taking: A Comprehensive Approach

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INTRODUCTION

Psychiatric history taking is a fundamental aspect of psychiatric evaluation, providing clinicians with crucial information to understand and address patients' mental health concerns effectively. ENCHANT explores the significance of a thorough psychiatric history, outlining key components and strategies to optimize the process, by adopting a systematic and holistic approach facilitating clinicians to better understand the complexities of each patient's condition, leading to more personalized and effective treatment interventions.

SOCIODEMOGRAPHIC DETAILS

It plays a significant role in psychiatry in understanding, assessment, treatment, and prevention of mental health disorders. Several sociodemographic factors are often overlooked but can significantly influence an individual's mental health and treatment outcomes. Commonly documented information includes the ID no., Name, Father's name, Age, Sex, Education, Occupation and Address of the patient for identification purposes and establishing rapport. Usually missed but equally important points include Religion, Spoken language, Socioeconomic status, Source of referral and ID marks, all of which aids in understanding the patient in a holistic, sociocultural perspective.

INFORMANT

Accumulating available information from the informant after obtaining consent from the patient is a crucial next step. Capability in assessing the adequacy and reliability of the informant is an important skill in psychiatric history taking, as it plays a vital role by providing additional context, corroborating or refuting patient's information, and offering insight into the patient's symptoms and functioning, particularly in situations where objective evidence of disease is lacking or unreliable, which is more common than not in psychiatric conditions.

ONSET, COURSE AND DURATION OF ILLNESS

The next critical step is to determine the appropriate onset, course and duration of the illness, as it helps in Diagnostic clarity ie., different psychiatric disorders often have distinct patterns of onset and course, Treatment planning and Prognostic consideration ie., conditions that have a stable course may have different treatment goals and outcomes compared to those with fluctuating or worsening symptoms, and to differentiate whether the decrease in symptoms observed is due to natural course of the illness or the treatment given. It may

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also help in risk assessment ie., it may also provide clues about potential risk factors or triggers for psychiatric emergencies, self-harm, or harm to others.

STRESSORS

The description of predisposing, precipitating and perpetuating stressors may be pivotal in many aspects as it can have a direct effect on physical as well as mental health, and indirect effect where stress may be expressed through health damaging behaviour. With evolving understanding on Psychoneuroimmunology and Psychoneuroendocrinology, the concept of stressors in psychiatric illnesses is further strengthened. Hence, there is a need to conceptualise stress unambiguously while history taking, which also helps in individualised non- pharmacological treatment strategies.

CHIEF COMPLAINTS AND HOPI

They provide a structured framework for understanding the patient's current symptoms, establishing rapport, guiding diagnosis and treatment planning, and monitoring progress throughout the therapeutic process.

Treatment History of current illness

Understanding the details of past treatment will lead to a better understanding of which treatments are viable alternatives and which to avoid. Fastidious review of prior medication trials provides valuable information to define reasonable treatment medication options and to rule out others.

PAST PSYCHIATRIC HISTORY

Most psychiatric disorders have a pattern of recurrence, and comorbidity is the rule rather than the exception. Some episodes of illness may have gone undiagnosed, especially milder forms of illness. Suicide and violence risk assessment is one of the vital information to be obtained and it has matured to offer an understanding that risk is a dynamic process influenced importantly by risk-enhancing and risk-reducing factors that has to be extensively evaluated. Establishing the patient's best functional baseline and the extent of recovery between episodes in case of episodic illness also provides a perspective on the impact of the problem(s) on the trajectory of the patient's life and helps to identify elements of a comprehensive treatment plan that optimizes fullest possible recovery.

PAST MEDICAL HISTORY

A well-developed past medical history archives both current and past major medical disorders, surgeries, hospitalizations and significant physical trauma, such as head injuries. In psychiatry, neurological and endocrine disorders are of particular interest because of the significant overlap in symptoms and signs with psychiatric syndromes. A thorough review of all current medications is essential because some medications used in other fields in medicine can create side effects that mimic psychiatric disorders and to identify potential drug–drug interactions before prescribing.

FAMILY HISTORY

Because many psychiatric illnesses have a genetic predisposition, if not cause, a careful review of family history is important to the assessment and can aid in diagnosis and establishing expected prognosis. Understanding that psychiatric disorders have a genetic component can help reduce stigma and promote empathy and understanding within families. It can also encourage family members to seek help and support each other in coping with mental health challenges.

PERSONAL HISTORY

Birth, Developmental and Childhood history

This reviews the stages of the patient's life from gestation to adolescence with an eye toward understanding the important exposures, relationships, and events that shaped the person's life story. It is also important in understanding the nature of the person's temperament and character and the degree to which the person has achieved developmentally appropriate role functions such as academic progress, work, peer and romantic relationships. Hence the gestational and birth history, developmental milestones and childhood development offer valuable information about early risk factors, neurodevelopmental trajectory, differential diagnosis, treatment planning, prognosis, and family dynamics.

Education and Occupation History

Education level can influence cognitive abilities, problem-solving skills, and access to resources. Occupation provides insights into daily functioning, social interactions, and stressors in the individual's life. The nature of one's job, work environment, job satisfaction, and level of occupational stress can impact mental well-being. High-stress occupations, job insecurity, or workplace conflicts may contribute to the development or exacerbation of psychiatric symptoms. Socioeconomic disparities can contribute to inequalities in mental health outcomes. Educational demands, career responsibilities, and occupational stressors can influence coping strategies and resilience. Individuals may develop adaptive or maladaptive coping mechanisms to deal

with academic or work-related stressors. Hence these are integral components of psychiatric assessment, providing valuable insights into cognitive abilities, socioeconomic status, stressors, coping strategies, and overall well-being.

Substance use History

Substance use can contribute to the development, exacerbation, or recurrence of mental health conditions. Many individuals with psychiatric disorders also struggle with substance use disorders, as dual diagnosis or comorbidity. Untreated substance use disorders can complicate the management of psychiatric symptoms and increase the risk of relapse. Conversely, untreated psychiatric disorders may contribute to substance use as a form of self-medication. It can also interfere with the effectiveness of psychiatric treatments. Understanding an individual's substance use history helps clinicians assess the severity of the problem and identify patterns of use. Addressing substance use in psychiatric care promotes patient-centered approaches to recovery and well-being.

Marital History

Marital history provides insights into the individual's past and current relationship dynamics, including patterns of communication, conflict resolution, intimacy, and support. Positive marital experiences characterized by emotional closeness, mutual respect, and effective communication can promote mental well-being, while marital discord, dissatisfaction, or conflict may contribute to stress, depression, or anxiety. It encompasses significant life transitions, such as marriage, divorce, widowhood, or remarriage, which impact mental health and adjustment. Understanding the context of these life changes is hence essential for providing appropriate support and intervention.

Sexual History

Sexual history can provide insights into potential risk factors for mental health issues, including sexual trauma, abuse, or exploitation. It also sheds light on the individual's experiences with relationships, intimacy, and sexual identity. Positive or negative experiences in romantic and sexual relationships can influence mental health and well-being. Issues related to sexual orientation, gender identity, sexual dysfunctions, or difficulties with intimacy may be relevant to psychiatric assessment and treatment planning. Addressing mental health concerns during pregnancy and the postpartum period improves maternal and infant outcomes.

Menstrual and Obstetric History

Understanding menstrual patterns and associated symptoms is crucial for identifying menstrual-related mood disorders, and hormonal influences on psychiatric symptoms. It also includes information about menopausal transition and associated symptoms such as hot flashes, mood changes, and sleep disturbances. Obstetric history is particularly relevant in perinatal mental health care, focusing on the mental health of individuals during pregnancy and the postpartum period. Addressing mental health concerns during pregnancy and the postpartum period improves maternal and infant outcomes. In summary, incorporating menstrual and obstetric histories into psychiatric assessments allows clinicians to consider hormonal influences, reproductive experiences, and gender-specific factors that may impact women's mental health and well-being.

Legal History

Legal history includes information about past encounters with law enforcement, involvement in legal proceedings, such as arrests, charges, convictions, or incarceration. Understanding the nature and circumstances of legal involvement helps clinicians assess risk factors, identify potential stressors, and address legal consequences that may impact mental health and well-being. In forensic psychiatry, legal history is central to assessing an individual's mental state at the time of the offense, competency to stand trial, criminal responsibility, and risk of future violence or recidivism.

PREMORBID PERSONALITY

Premorbid personality serves as a baseline for evaluating changes in behavior, mood, and functioning associated with the onset of psychiatric symptoms. Comparing current symptoms to premorbid personality traits helps clinicians identify deviations from the individual's typical patterns of behavior and functioning, aiding in diagnostic formulation and treatment planning. Premorbid personality characteristics may influence the onset, course, presentation of psychiatric symptoms and contribute to diagnostic considerations. Incorporating premorbid personality assessment into psychiatric evaluations enhances diagnostic accuracy, treatment planning, and therapeutic interventions tailored to the individual's unique personality profile and clinical presentation.

GENERAL PHYSICAL AND SYSTEMIC EXAMINATION

Physical examination allows clinicians to assess for signs of medical conditions that may impact mental health. Certain medical conditions, such as thyroid disorders, neurological disorders, endocrine disorders, infectious diseases, and cardiovascular diseases, can present with psychiatric symptoms or exacerbate existing mental

health issues. Identifying and addressing these medical conditions is essential for comprehensive psychiatric care. It helps monitor for medication-related adverse effects, such as weight gain, metabolic changes, cardiovascular effects, or movement disorders. Systemic examination also includes a neurological assessment, that may indicate underlying cognitive impairments, or brain injuries that can impact mental health and functioning. Incorporating physical health assessment into psychiatric evaluations enhances diagnostic accuracy, treatment planning, and overall health outcomes for individuals.

MENTAL STATUS EXAMINATION

It is a standardised format in which the clinician records the psychiatric signs and symptoms present at the time of the interview. It is a systematic collection of the observations and reported mental experiences that produce a picture of the patient's current mental state and functioning. MSE conducted in a structured and systematic manner, with findings documented to inform diagnostic impressions, treatment planning, and ongoing monitoring of the individual's mental health status, provides a comprehensive evaluation of the individual's mental state and functioning, guiding clinical decision-making and interventions in psychiatric care.

HIGHER MENTAL FUNCTION

Domains of cognitive function important to the initial assessment include level of alertness, orientation, attention/concentration, visual-spatial function, memory (registration and recall), calculation, receptive and declarative language functions, fund of knowledge, capacity to abstract, and executive functions including insight and judgment. Assessing and promoting higher mental functioning, apart from providing a clue in diagnosis, is important in cognitive rehabilitation, psychotherapy, and interventions aimed at enhancing cognitive skills and psychological resilience.

DIAGNOSTIC FORMULATION

It is a concise statement of the case, a discussion about alternative ideas about diagnosis, aetiology, treatment and prognosis and of the arguments for and against each alternative. A good formulation is based on the facts of the case and not on speculation. It is concerned with not only the disease concepts, but also with the understanding how the patient's lifelong experiences have influenced his personality and his ways of reacting to adversity'. Hence it is essentially 'an analysis and integration of information'.

CONCLUSION

The noble impulse to rapidly help the patient is only noble if well placed and well timed. Hence, clinicians need to see that the more complete the history is, the better the chance to direct that impulse for good. Good treatment demands the best possible history, and despite the unrelenting competing pressures, mental health clinicians should still aim high and we believe ENCHANT is a tool aimed in guiding us on the path of comprehensive psychiatric history taking.

Scan the QR code to get ENCHANT – An Enhanced Psychiatric History Taking Manual.

Feedbacks, Suggestions and Criticisms are welcome – e.palm2024@gmail.com

ENCHANT - **E**stablish rapport, **N**ote symptoms, **C**ollaborate with patient and Informant, **H**istory exploration, **A**ssessing Mental status, **N**ote risk factors, **T**ailor treatment approach based on patient's needs.

For the full article along with the complete performa, referred to Journal website (www.ijmhns.com)

ENCHANT PERFORMA

SOCIO DEMOGRAPHIC PROFILE

SOCIA DEMOGRAPHIC PROFILE: **DATE:**

ID no Name	Hospital documentation & identification purpose. Documentation, identification & helps to establish rapport with patients
Father's/Husband's Name	Identification becomes difficult with own name if there are two individuals with same name.
Age(in yrs)	To prepare interview style. Legal validity of information, to narrow down diagnosis in relation to age, for planning management, to evaluate prognosis.
Sex	1.Male ( ) 2.Female ( ) 3.Other ( ) To narrow down diagnosis in relation to sex, to evaluate prognosis
Religion	1.Hindu ( ) 2. Christian ( ) 3. Muslim ( ) 4. Other ( ) To understand the prevailing belief system, for planning management and support.
Mother tongue	Tamil speaking / other language It is preferable to conduct the interview in mother tongue of the patient.
Marital status	1.Single ( ) 2.Married ( ) 3.Seperated ( ) 4.Divorced ( ) 5.Widow ( ) For planning management - Eg: prescribing a teratogenic drug to a reproductive age female, to evaluate prognosis and social support of the patient.
Education	1. Illiterate ( ) 2.Primary class ( ) 3.Middle school ( ) 4.Higher school ( ) 5. Higher secondary school ( ) 6.Graduate ( ) 7.Post graduate ( ) 8.Specify … … … For planning management especially non- pharmacological, may give clue to the underlying intellectual level.
Occupation	1. Not working ( ) 2.Working ( ) 3.Specify For planning management - Eg: prescribing a sedative drug to a night shift worker To assess impact of illness on occupation
Socio economic status	Based on Modified Kuppuswamy scale. [1] 1.Upper ( ) 2. Upper middle ( ) 3. Lower middle ( ) 4. Upper Lower ( ) 5. Lower ( )
Source of referral	1.Self ( ) 2.Patient( ) 3.Other department ( ) 4.Others(Specify) Legal validity - Eg: case referred from magistrate for evaluation Discussion with the referral source prior to the first interview is helpful to add additional clarity to the purpose of the referral and to obtain nuanced background information. [3]
Identification marks	Traceable and permanent marks should be mentioned. Common moles should be avoided. Proper anatomical location should be mentioned. 1. 2. Legal identification (Eg: patient running away from hospital, uncooperative or unknown patients found alone or wandering in streets)
Address with phone number	For communication if required. To know how far from the patient is coming, so that to formulate the frequency of follow up

Table 1. Sociodemographic profile

INFORMANTS

To take the patient's consent before taking this collateral history unless the patient does not have capacity to consent. [2]

- **Limited Insight:** Patients may minimize or deny their symptoms due to stigma, fear, or lack of insight.
- **Memory Impairment:** Affects the accuracy of self-reported history.
- **Behavioural Observations:** Informants can offer valuable observations of the patient's behaviour, mood changes, and interactions over time, which may not be evident during brief clinical encounters.
- **Diagnostic Confirmation:** Informant history can help corroborate or refute the patient's self-reported symptoms, aiding in the diagnostic process.
- **Treatment Planning:** Understanding the patient's social support system, living environment, and interpersonal relationships through informant history.

S.no	Informants name	Relationship with patient [13]	How long informant is in touch with patient	Adequacy	Reliability
				• Information given is sufficient for forming a diagnosis or not.[5] • Intellectual and observational ability.[2] • Degree of concern regarding the patient. [2]	It refers to the likelihood that similar results will be obtained by different observers.[5] **Contact**- between the patient and informant **Closeness**- of relationship between the patient and informant **Continuity**- of the account given by informant **Consistency**- of the verbatim of the informant, with in the informant at different interview. **Corroborativeness**- between various sources of information **No motive to give wrong information**

Table 2 – Informant details

TOTAL DURATION OF ILLNESS

(calculated from the day of onset of first behavioural change to till now)

MODE OF ONSET

Onset is defined as the time span from the beginning of the first symptom to the time of developing a full blown diagnosable psychiatric syndrome.

1. Sudden – Sudden appearance of signs and symptoms within minutes to hour.
2. Acute - Rapid onset of signs and symptoms within hours to day.
3. Sub-acute – Onset of signs and symptoms within days to week.
4. Gradual - Onset of signs and symptoms within weeks to month.
5. Insidious - Onset of signs and symptoms develop over months to years so gradually, that it is difficult to ascertain when the onset exactly occurred.

COURSE OF ILLNESS

Course of an illness refers to the usual trajectory the

disease follows from the moment of exposure to causal agents until recovery or death. In mental disorders, where the cause of illness is not known exactly, course is described from the onset of first symptom.

1. **Continuous** - Characterised by uninterrupted change without breaks or with steps infinitely small and thus not detectable.[5] The symptoms of the illness never disappear completely throughout the course of the illness.

   1a. with Exacerbation –

   a. Waxing and waning course
   b. Progressive course
   c. Static course

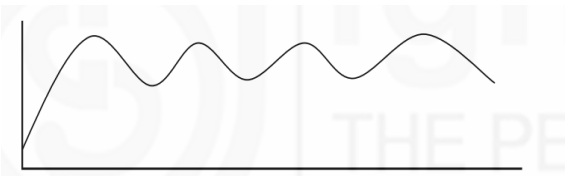

Fig. 1: Waxing and waning course

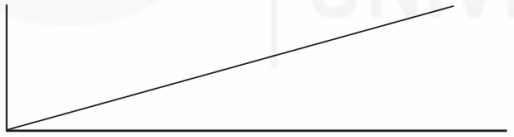

Fig. 2: Progressive course

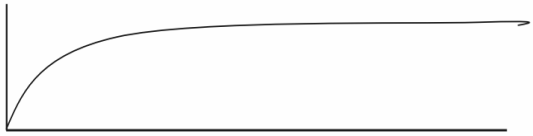

Fig. 3: Static course

Table 2 – Informant details

2. **Episodic** - An illness can be said episodic when it has an onset and an offset of signs and symptoms of the disease with periods of recovery in between at least for a period of 2 months.

   2a. Duration of current episode –

3. **Fluctuating**

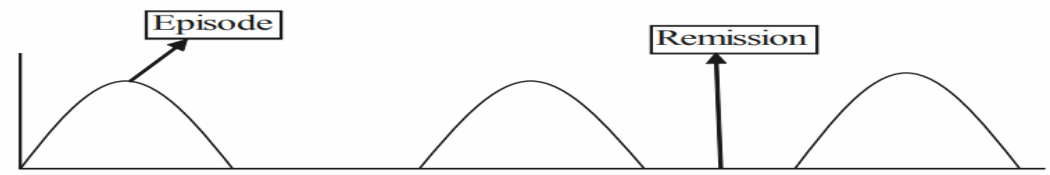

Fig. 4: Episodic course

PROGRESS OF ILLNESS

To what extend has the patient's symptomatology represented an evolution over time.[5]

- Improving- Improving from the date of onset
- Deteriorating-Condition is getting worse by time

STRESSORS: FACTORS IN ILLNESS [5]

- Predisposing factors- Factors operating from early life that determines a person's vulnerability to develop a disorder or likelihood that person will develop certain symptoms under given stress conditions.
- Precipitating factors- Events that occur shortly before the onset of a disorder and act as physical or psychosocial stressors and lead to the onset of disorder in a person who may be predisposed to develop the disorder
- Perpetuating factors- Factors due to which the disorder is maintained or aggravated.
  - Biological
  - Psychological
  - Social

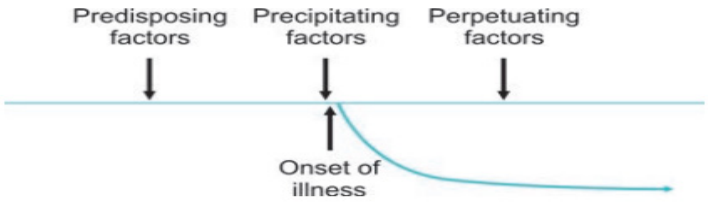

Fig. 5: Factors in Illness

CHIEF COMPLAINTS

Write in patients words in chronological order - with the earliest complaint first and recent most being last.[5]

Patient:	**Informant:**
1.	1.
2.	2.

HOPI (History of Present Illness)

When the patient was last asymptomatic should be clearly noted.[2]

Patient's report

It should take precedence over the other informants' report. If the patient has no complaints or he denies symptoms (due to absent insight), or is non communicative this fact should also be noted. [2]

Informant's report

Report of the collaterals including other health care providers, family, and other caregivers. [4]

1. Document complete relevant information from the day of onset of first behavioural change to till date in case of continuous illness.
2. Document complete relevant information from the day of onset of behavioural change in this episode to till date in case of episodic illness.
3. The essential questions include what (symptoms), how much (severity), how long, and associated factors. Identify why the patient is seeking help now.
4. Establish psycho pathology and diagnostic criteria.
5. Document the level of dysfunction (biological, psychological, social and occupational).
6. Document relevant negative history.

Limiting factors

Factors which limit the illness from an extensive progress and may include factors such as good social support or treatment during the course of illness.[5]

Modifying factors

Factors which modify natural or expected course of the illness. This includes factors such as use of substance by a patient with Schizophrenia which may lead to affective colouring of illness, use of antidepressants causing a manic switch in patient with depressive illness [(5)]

To summarize, HOPI should cover major headings under acronym of **ABCD**[5]

- ***A - Affect***
- ***B - Biological functions***
- ***C - Complaints in behaviour***
- ***D - Daily living activities***

TREATMENT HISTORY:

Duration of untreated illness

S.No	Who?	Voluntary / not	OP/ IP	Nature and Modality of Rx	Duration	Response	Reason for discontinuation
	Psychiatrist Psychologist Physician Neurologist Temple priest Faith healer Astrologer Traditional / alternate medicine practitioner			Pharmacological Psychological Faith healing Traditional / Herbal / alternate medicine methods Individual/ group therapy			

Table 3 – Pathway of treatment

S. no	Psychotropic Medication	Dose range	Duration	Compliance / Reason for poor compliance	Response	Adverse effects	Allergies

Table 4 – Psychotropic medication details

Drug compliance

Compliance is defined as the extent to which the patient's behaviour (in terms of taking medications, following diets or executing other lifestyle changes) coincides with medical recommendations.[5]

MEDICAL HISTORY

Medical conditions both past and present

- DM/ HT/ BA/ TB/ CAD / CVA/ Thyroid disorders/ Head injury/ Seizures / LOC/ Syphilis/ HIV/ OTHERS
- Any past surgeries

PAST PSYCHIATRY HISTORY

- Complete information of past episodes in case of episodic illness.
- Complete information of past symptoms of other psychiatric disorders, when they occurred, how long they lasted, and the frequency and severity of episodes. [4]
- Inter episode period of functioning.[5]
- Past treatment should be reviewed in detail.[4]

S.No	Who?	Voluntary / not	OP/ IP	Nature and Modality of Rx	Duration	Response	Reason for discontinuation
	Psychiatrist Psychologist Physician Neurologist Temple priest Faith healer Astrologer Traditional / alternate medicine practitioner			Pharmacological Psychological Faith healing Traditional / Herbal / alternate medicine methods Individual/ group therapy			

Table 5 – Pathway of treatment

S.No	Who?	Voluntary / not	OP/ IP	Nature and Modality of Rx	Duration	Response	Reason for discontinuation
	Psychiatrist Psychologist Physician Neurologist Temple priest Faith healer Astrologer Traditional / alternate medicine practitioner			Pharmacological Psychological Faith healing Traditional / Herbal / alternate medicine methods Individual/ group therapy			

Table 6 – Psychotropic Medication Details

Special consideration

- Past suicidal ideation
  - Intent and plan
  - Attempts including the nature of attempts
  - Perceived lethality of the attempts
  - Saving potential
  - Suicide notes or other death preparations
  - If the patient has not acted upon these urges, what has prevented him or her from acting on these thoughts
- Non suicidal self-injurious behaviour including history of cutting, burning, banging head, and biting oneself.
- Violence and homicidality history

A life chart provides a valuable display of the course of illness, episodic sequence, polarity (if any), severity, frequency, relationship to stressors, and response to treatment, if any.[2]

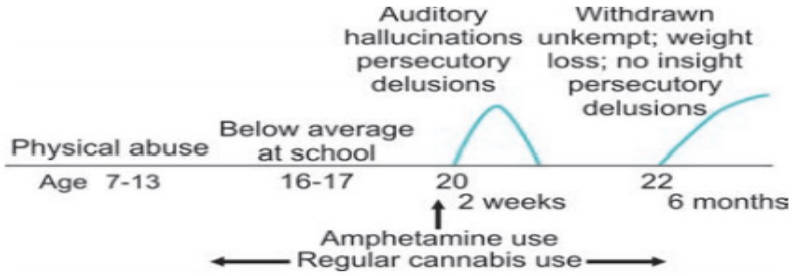

Fig 6: Example of Life chart

FAMILY HISTORY

Draw a pedigree chart of 'family of origin'. [2]

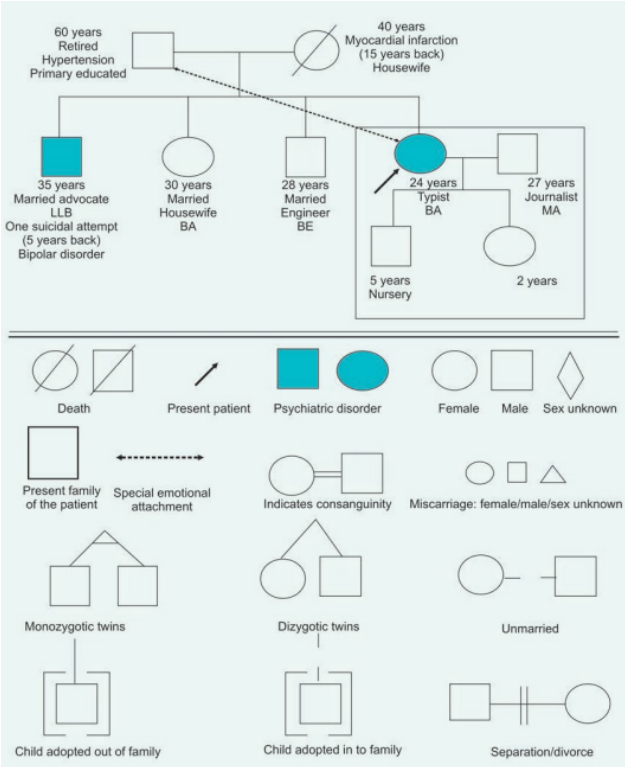

Fig. 7: Pedigree chart

Family type: nuclear, extended nuclear or joint family.[2]

Consanguinity: [8]

- 1st degree – parent
- 2nd degree – sibling/ grandparent/ grandchild
- 3rd degree – Uncle/ aunt/Niece/nephew/ Great-grandparent/ Great-grandchild
- 4th degree – First cousin/ Great great grandparent

Family history of psychiatric illness, substance use disorders, and lethality history or person whose whereabouts not known

Family history of Medical illnesses

Relationships amongst family members:

PERSONAL HISTORY

Antenatal	1. Generally good () 2. Exanthematous Lesions () 3. X-ray Exposure() 4. Attempted Abortion () 5. Any drug use () 6. Others Eg: Febrile illness (schizophrenia etiology- prenatal exposure to influenza epidemics, maternal starvation during pregnancy, Rhesus factor incompatibility, and an excess of winter births [(1)] Whether it was a planned or unplanned conception? [13]
Birth history	• Whether the delivery was full term, preterm or post term? • Place (home/ hospital/ other) and type of delivery (normal/ instrumental/ episiotomy/ caesarian section), • Any other complication during delivery such as abnormal presentation, cord around neck, prolapsed cord, multiple pregnancy or congenital anomaly noticed immediately after birth

Post natal	1. Jaundice 2. Cyanosis 3. Delayed Cry 4. Convulsions in period immediate after birth and early childhood. 5. Others - any injury at the time of birth 6. Birth weight 7. What was the mode of feeding after birth, any problems associated with feeding, age at weaning, recurrent infections, significant injury.[5]
Immunization	1. Complete ( ) 2. Incomplete ( ) up to age
Developmental mile stones	1. Neck holding… … … ….(3-6 months) 2. Sitting… … … …(4-7 months) 3. Crawls… … … …(8 months) 3. Tooth eruption… … ….(8-12 months) 4. Standing (unsupported)… … ….12-14 months) 5. Walking… …..(14-15 months) 6. First word … …..(13-15 months) 7. Three word sentences… …..(16-18months) 8. Bowel control… …..(24-48 months) 9. Bladder control… … …(60-72 months)
Temperament – psychological tendencies with intrinsic paths of development that reflect the personality traits.[6]	If the age is less than 16 years.[2] 1. Activity ( ) 2. Adaptability ( ) 3. Rhythmicity ( ) 4. Approach withdrawal ( ) 5. Threshold of responsiveness ( ) 6. Intensity of emotion ( ) 7. Quality of mood ( ) 8. Distract ability ( ) 9. Attention span ( )
Childhood[1]	1. Childhood home environment including members of the family [4] 2. Number and quality of friendships [4] 3. Childhood physical and sexual abuse should be carefully queried [4] 4. Neurotic traits (nail-biting, thumb sucking, food-fads, head banging, body rocking, stuttering, stammering, mannerisms, temper tantrums, bedwetting, phobias, night-terrors, sleep walking, etc.) [2] 5. Temper tantrums when present, extent and intensity.
Play [2]	What games were played at what stage, with whom and where. Relationships with peers, particularly the opposite sex, should be recorded. The evaluation of play history is more important in the younger patients.
Education	1. Started schooling at the age of 2. Studied up to 3. Reason for not continuing study [2] 4. Academic performance and extra-curricular activities 5. Any school refusal/ truancy 6. Any remarks from Educational institution 7. Learning disorders, behavioral problems at school [4] 8. Relationships with peers and teachers [2]
Occupation	1. Started working at the age of 2. Type of job [4] 3. Performance at job [4] 4. Any disciplinary action taken 5. Change in job & reason 6. Duration at each work place – chronological order of job held [2] 7. Reasons for leaving [5] 8. Current work status 9. Nature of relationships with supervisors and coworkers [1] and subordinates [2] 10. Job satisfactions and ambitions [2] 11. The patient's income, financial issues, and insurance coverage [1]

Substance use history [4]	1. Which substances have been used, including alcohol, drugs, medications (prescribed or not prescribed to the patient), gambling, binge eating 2. Routes of use (oral, snorting, or intravenous) 3. The frequency and amount of use(patients tend to minimize or deny use) 4. Tolerance, the need for increasing amounts of use 5. Withdrawal symptoms should be established to determine abuse vs dependence. 6. Impact of use on social interactions, work, school, legal consequences, and 7. Driving while intoxicated (DWI) 8. Any periods of sobriety, length of time and setting (religious, jail, legally mandated, inpatient detoxification, outpatient treatment, group therapy, or other settings including self-help groups, Alcoholics Anonymous (AA) or Narcotics Anonymous (NA), halfway houses, or group homes)
Menstrual history	1. Menarche at the age of 2. Cycles regular / irregular (Days/frequency – eg: 5/30 cycle) 3. The age of appearance of secondary sexual characteristics (2) 4. LMP 5. If attained menopause 6. Any other specific
Sexual history	1. First information about sex and its source 2. sexual orientation 3. sexual identification of self, 4. any specific taboo or belief, 5. masturbation habits, (fantasy and activity) [2] 6. premarital/extramarital sex, 7. exposure to high risk sexual behavior (protected/un protected), 8. History of childhood sexual abuse. [5] 9. H/S/O Deviant sexual behavior
Legal history	Any pending charges or lawsuits [4] Military history, where applicable, should be noted including rank achieved, combat exposure, disciplinary actions, and discharge status. [4] Availability of Advance directive and Nominated representative may also be enquired and noted

Table 7 – Personal History

Marital History

1. Draw a pedigree chart of 'family of pro creation'. [2]
2. The duration of marriage(s) and/or relationship(s) [2]
3. marriage arranged by parents with or without consent, or by self-choice with or without parental consent.[2]
4. number of marriages, divorces or separations.[2]
5. mode and frequency of sexual intercourse, sexual satisfaction.[2]
6. Current family structure. [4]
7. Relationship with family members. [4]
8. Specific questions about domestic violence and outcome of the victim. [4]

Obstetric history

1. Obstetric formula GPLA
2. How many children, what type of delivery, whether alive and healthy?
3. Any termination of pregnancies. If so, why? [2]
4. Any perinatal psychiatric issues

PRE MORBID PERSONALITY

Personality is the dynamic organization within the individual of those psycho-physical systems that determine his unique adjustment to his environment. [7]

1. Social relations:
   a. How were his relation to family (attachment, dependence);
   b. to friends, groups, societies, clubs
   c. to work and work-mates (leader or follower, aggressive or submissive, organizer, ambitious, adjustable, independent) [5]
2. Intellectual activities, hobbies and use of leisure

time [5] - energetic/ sedentary.[2]

3. Predominant mood - cheerful or despondent; worrying or placid; strung up or relaxed; optimistic or pessimistic; self-depreciative or satisfied?[2]
   a. Could he express feelings of love, anger, frustration or sadness
   b. Did he loses control over feelings, had he been violent? [5]
4. Character: [5]
   a. Attitude towards self – Self-confidence level; self-criticism; self-consciousness; self-centred/thoughtful of others; self-appraisal of abilities, achievements and failures.[2]
      - Strengths and abilities, shortcomings, ability to plan ahead, resilience in face of adversity, hopes and ambitions?
      - Was the level of aspiration high or low?
      - Was he self-critical and perfectionist or self-approving and complacent in relation to own behaviour and achievements?
      - Was he steadfast in face of difficulties or intolerant to frustration? [5]
   b. Attitude to Work & Responsibility:
      - Did he welcome responsibility or was worried by it
      - Made decisions easily or with difficulty?
      - Was he methodological or haphazard in his approach?
      - Was he flexible or rigid?
      - Was he cautious, foresightful and given to checking or impulsive?
      - Was he determined towards goal or used to get bored or discouraged easily?
   c. Interpersonal relationships:
      - Was he self-confident or shy and timid?
      - Was he insensitive or sensitive to criticism?
      - Was he trusting or suspicious and jealous?
      - Was he selfish and egotistical or unselfish and altruistic?
      - Was he emotionally controlled or irritable and quick tempered?
      - Was he tactful or outspoken?
      - Did he use to enjoys or avoids self-display?
      - Was he quiet and restrained or expressive and demonstrative in speech and gesture? Was he tolerant or intolerant to others?
      - Was he adaptable or unadaptable?
      - Did he use to prefer company or solitude?
      - Was he shy or used to make friends easily, were relationships close and lasting?
      - How he used to handle others' mistakes,
      - Did he always want to be centre of attention?
      - How was the relation with work-mates or superiors?
   d. Standards in moral, religious and health matters: tolerance of others' standards and beliefs.[2]
   e. Energy, initiative:
      - Was he energetic or sluggish?
      - Was output sustained or fitful?
      - Did he used to get easily fatigued?
      - Were there regular or irregular fluctuations in energy or work output?
5. Fantasy life: What was the frequency and content of day dreaming? Sexual and nonsexual fantasies, recurrent or favourite daydreams.[2]
6. Habits: Use of alcohol, drugs, tobacco; comment on food and sleep pattern.[2]

GENERAL PHYSICAL EXAMINATION

- Consciousness – State of awareness, with response to external stimuli. [3]
  - *A. Rate: Alert_____ Drowsy_____ Lethargic_____ Stupor_____ Coma_____ [14]
  - *B. Describe stimulus necessary to arouse patient, and record patient's response.[14]
- Pallor ( ), clubbing ( ), jaundice ( ), cyanosis ( ), generalized lymphadenopathy ( )
- Vitals: **PR.....** **BP.....** **RR.....** **TEMP.....**
- Alcohol - Signs of Liver failure (Alopecia, parotid swelling, spider naevi, foeter hepaticus), Tremors on outstretched hands, any bruises or abrasions.
- Nicotine – Nicotine stains on teeth
- Inj use – puncture marks on cubital fossa / wrist
- Others: self- inflicted cuts on forearm / other parts, tattoo marks, skin lesions
- Fullness of neck – Thyroid swelling – Moves with Deglutition/ protrusion of tongue

SYSTEMIC EXAMINATION

CVS: [9]

- Pulse of the patient - at least radial and femoral pulse.

- Comment on rate, rhythm, volume, character, arterial wall, radio-radial and radio-femoral delay.

- Blood pressure in right upper arm in both supine and erect position.
- Look for neck veins, any engorgement and jugular venous pressure.
- Conduct a thorough inspection, palpation and auscultation of precordium

RS: [9]

- Bare the chest of the patient
- Inspection (rate and character of respiration, chest wall movements);
- Palpation (position of trachea, swelling, tenderness, fremitus);
- Percussion (character of note, symmetry);
- Auscultation (breath sounds, added sounds, if any).

Abdomen: [9]

- Bare abdomen
- Inspection (shape, distention, movements, veins, umbilicus, visible peristalsis)
- Palpation (tenderness, rigidity, organomegaly, hernial orifices, genitalia)
- Percussion (character of note, shifting dullness, fluid thrill)
- Auscultation (peristaltic sounds, arterial bruits, succession splash).

CNS: [9]

- Motor system:
  - Strength, bulk, tone, co-ordination of all major muscles
  - Deep tendon and superficial reflexes
- Sensory system:
  - Pain, touch, temperature, position, vibration.
  - Cortical sensations
- Autonomic system
- Cerebellum
- Meningeal signs
- Handedness, spine, gait, fundus.

MENTAL STATE EXAMINATION

General Appearance And Behaviour

Behaviour – Sum total of the psyche that includes impulses, motivations, wishes, drives, instincts, and cravings, as expressed by a person's behaviour or motor activity. Also called conation. [4]

- General Physical Appearance [5]
  - Kempt
  - Overtly made up
  - Unkempt and untidy
  - Sickly
  - Perplexed
- Estimation of age[5]
  - Appropriate to age
  - Younger that stated age
  - Older than stated age
- Body built [4]
  - Emaciated
  - Thin built
  - Moderately built
  - Well built
  - Obese
- Touch with surroundings: [4]
  - Present: Patient is oriented; has normal perception of self in respect to surroundings.
  - Partial: Some aspect of his surroundings or their significance to the patient is lost.
  - Absent: Patient is unable to orient himself and behaves in a manner inappropriate to the situation.
- Eye contact with the examiner: [5]
  - Partial: Fleeting eye contact with the examiner.
  - Absent: Here, there is complete loss of eye contact with the examiner.

  Gaze Aversion ( ) Staring Vacantly ( ) Staring at the Examiner ( ) Hesitant Eye Contact ( ) Normal Eye Contact ( ) [2]
- Dress[5]
  - Appropriate: Dress is properly worn, clean and in conformity with the situation.
  - Shabby: Neglect or decreased care for dress occurs concurrently with neglect of other aspects of appearance.
  - Inappropriate: Dressing is said to be inappropriate when it is not done in conformity with the situation.
- Facial expression[5]
  - Depression - corners of mouth are turned down and there are vertical furrows on the brow
  - Anxious - horizontal creases on the forehead, widened palpebral fissures and dilated pupils.
  - Mania - elation, irritability and anger.

- Drugs with Parkinsonian side effects - Fixed wooden expression.

- Posture[5]
  - Depressed - hunched shoulders, with head and gaze inclined downwards.
  - Anxious - sit on the edge of the chair with hands gripping its sides. Anxious patients and those with agitated depression may be tremulous and restless, touching their jewellery or picking at their fingernails.
  - Mania - restless.
  - Catatonia - odd postures.

- Attitude towards examiner: [5]
  Attitude is a mental and neural state of readiness organized through experience; exerting a directive and dynamic influence upon the individual's response to all objects and situations with which it is related.
  - Co-operative: Helps the examiner conduct the interview smoothly.
  - Attentive: Patient pays attention to the interviewer.
  - Defensive: It is the kind of behaviour that turns the examiner's attention away from one's deficiencies, or behaviour that might cause him guilt or embarrassment.
  - Frank: This behaviour helps to conduct an open conversation that includes all the deficiencies without guilt or embarrassment.
  - Hostile: It is characterized by behaviour of covert aggression, so that it tends to create strong negative feelings or anger in the examiner or the patient himself shows anger towards the examiner.
  - Seductive: The patient tries attention-seeking behaviour that uses verbal or non-verbal seductive clues towards the examiner.
  - Guarded: Patient will restrict his information and weigh the information as per his/her ideas of importance.
  - Evasive: Patient attempts to escape from an argument and shifts topics.

- Rapport: It is a bidirectional empathetic relationship, which the examiner shares with the patient.
  - Easily established and maintained
  - Established with difficulty and maintained or not
  - Not possible even with difficulty

- Any hallucinatory behaviour - Behaviour suggestive of active hallucinations. It may be in the form of suddenly making postures of listening, looking intently at some point or talking in response to imaginary voices. [5]

- Tics - rapid, repetitive, coordinated and stereotyped movements, most of which can be mimicked and are usually reproduced faithfully by the individual.[11]

- Mannerism - Ingrained, habitual involuntary movement.[4] Unusual repeated performances of a goal directed motor action or the maintenance of an unusual modification of an adaptive posture. [5]

- Stereotypy - Continuous mechanical repetition of speech or physical activities.[4] A stereotyped movement is repetitive, non-goal directed action, which is carried out in a uniform way. [10]

- Grimace: It is a specific facial expression, which is non-goal directed & spontaneous. [5]

- Silly Smiling: Apparently spontaneous and childish laughter on little provocation. [5]

- Gestures- A mode of non-verbal communication in which information is conveyed by movements of hands, arms or parts of the body. [5]

PSYCHO MOTOR ACTIVITY

Motor manifestation of psychic activity [4]

Akinesia - Lack of physical movement, as in the extreme immobility

Bradykinesia - Slowness of motor activity, with a decrease in normal spontaneous movement.

Hyperkinesia: Abnormality in motor behaviour that can manifest itself as psychomotor agitation, hyperactivity.

- Retardation: Motor retardation implies slowness of the initiation, execution and completion of physical activity.
- Restless: purposeless movement of extremities, limbs; fiddling, stretching, shifting, cannot sit still, standing up and sitting again.
- Destructive: Breaking/ throwing or disrupting items nearby.
- Self-injurious: Behaviour characterized by doing self-harm or inflicting injuries on oneself. It is usually viewed as having a psychological meaning i.e. attention seeking.
- Odd posturing- Voluntary assumption of inappropriate or bizarre posture. The position may be maintained voluntarily or imposed by the examiner. The maintenance should be atleast for one minute.

- Rigidity- Assumption of a rigid posture against all attempts to move.

SPEECH

A conditioned motor reflex used as a means of articulatory and phonemic expression of language.[8]

- Spontaneous[2] - On his own / Response to questions when asked or spoken to.
- Relevant - Answer that is not responsive to the question.[1] There is relevance between the question and the answer given by the patient but the answer may not be correct. E.g. where is your home? – America. [5]
  Irrelevant - Grammatically correct meaning of speech but is unrelated to the question asked. E.g: where is your home? – the box is blue in colour.
- Coherent -communication that is disconnected, disorganized, or incomprehensible[4]
  Understandibility of the speech. [5]
- Reaction time - The time taken by the patient from listening the question to answering. [5]
  - Increased reaction time- Time taken is increased or response to stimulus is delayed.
  - Decreased reaction time- Time taken is decreased.
- Rate – the number of words spoken by a person per minute
  - Whether speech is present or absent (mutism)
  - If present, whether productivity is increased or decreased
  - Eg: Pressure of speech (>150 words in a minute is pressure of speech) or poverty of speech.
- Tone - The relative highness or lowness of a pitch / tone as perceived by the ear. [5]
  Prosody: Melodic intonation (changes in pitch and accentuation of syllable and words) and emotional valence of speech.
  - Monotonous- Speech without change in pitch or lack of modulation.
  - Audible- The examiner can listen to the voice of the patient.
  - Excessively loud- Intensity of speech is louder than required.
  - Abnormally soft- Intensity of speech is softer than required.
- Volume - Amount the patient speaks on a particular subject
- Deviations
  - Rhyming and punning- Rhyme is sameness of the sounds of the endings of two or more words. i.e. I am going… rowing… especially at the end of lines or verses; Punning is humorous use of words with similar meanings of a word with double meaning i.e. both me and my bike need fluid.
  - Slurring- A form of speech in which the words are pronounced with prolongation of syllables.
  - Stuttering/Stammering- The disorder of rhythm of speech in which the normal flow is interrupted by pauses, prolongations or repetition of sounds, or fragments of words i.e. syllables.
  - Whispering: Production of sound by using breath but not vocal cords.
  - Muttering- Speaking in a low voice, not meant to be heard (using lip movement).
  - Clang association- Association or speech directed by the sound of a word rather than its meaning; words have no logical connections.[3]
  - Stereotypy- Continuous mechanical repetition of speech or physical activities.[3]
  - Perseveration- Pathological repetition of the same response to different stimuli as in a repetition of a same verbal response to different questions. Persistent repetition of a specific word or concept in the process of speaking.[3]
- Verbal Fluency:

  Total animals: _____
  Total words: _____

MOOD

Pervasive and sustained feeling tone that is experienced internally and that, in the extreme, can markedly influence virtually all aspects of a person's behaviour and perception of the world.[4]

AFFECT

The outward expression of the immediate, cross-sectional experience of emotion at a given time.[2]

- Subjective
- Objective
- **Quality** - the label or valence of the affect
  - Dysphoric- An affect characterised by sustained emotional states such as sadness, anxiety or irritability. [5]
  - Euthymia - Normal range of mood, implying absence of depressed or elevated mood.[4]
  - Apathy - Dulled emotional tone associated with

detachment or indifference[4]
  - Elevated - Air of confidence and enjoyment; a mood more cheerful than normal but not necessarily pathological. [4]
  - Euphoria - Exaggerated feeling of well-being that is inappropriate to real events. [4]
  - Elation - Mood consisting of feelings of joy, euphoria, triumph, and intense self-satisfaction or optimism[4] with increased PMA
  - Exhaltation - Feeling of intense elation and grandeur. [4]
  - Ecstasy – Severe elevation of mood, intense sense of rapture or blissfulness. [4]
  - Irritable - State in which one is easily annoyed and provoked to anger. [4]
  - Anxious- Feeling of apprehension caused by anticipation of danger which may be internal or external.[5]

- Intensity - strength of the emotional expression. [5]
  - ***Shallow affect*** - When there is lack of depth in emotion. [5]
  - ***Blunted affect*** - Disturbance of affect manifested by a severe reduction in the intensity of externalized feeling tone. [4] Greatly diminished emotional response or expressionless face and a uniform voice, irrespective of the topic of conversation, patient is indifferent to distressing topics. [5]
  - ***Flat affect*** - Absence or near absence of any signs of affective expression. [4]

- **Mobility** - It is the ease and speed with which one moves from one type to another type of emotion. [5]
  - ***Appropriate*** - Emotional tone in harmony with the accompanying idea, thought, or speech.[1]
  - ***Constricted*** - Reduction in intensity of feeling tone that is less severe than that of blunted affect.[1] Reduced mobility of affect. [5]
  - ***Fixed*** - When affect is extremely constricted to one emotion it is called fixed or immobile.
  - ***Lability*** - Excessive emotional responsiveness characterized by unstable and rapidly changing emotions[4] rapid shift from one type to another emotion without persistence of any affect. [5]

- **Range** - variety of emotional expression noted in a session. [5]
  - Full Range - appropriately expressed many emotions depending on the context have a full or broad range of affect.
  - Restricted range - person shows only a fixed emotion or reduction in the range of emotional expression.

- **Reactivity**- The reactivity is the extent to which affect changes in response to enviormental stimuli. When patient does not respond to examiner's provocation in the form of joking, for instances, the affect is said to be non-reactive.

- **Appropriateness** - congruence or fit between the expressed quality of emotion and the content of speech, thought, expected degree of intensity and the overall situation.

- **Diurnal variation of affect** - The change in affect occuring with passage of the day.
  - Worse in morning
  - Worse in the evening
  - Worse at night

THOUGHT

- Form - Presence of logical connection between words and sentences formed
  Formal thought disorder: Disturbance in the form of thought rather than the content of thought.[4] Thinking characterized by
  - loosened associations
  - neologisms
  - Clang associations
  - Derailment
  - Neologism
  - Tangentiality

- Flow [10]
  - Tempo
    - Flight of ideas
    - Inhibition or Slowing of thinking
    - Circumstantiality
  - Continuity
    - Perseveration
    - Thought blocking

- Content
  - Depressive cognitions (Beck's triad)
  - Suicidal risk and death wishes: (Intentionality, Lethality)
  - Delusions:
    1. False- firm-fixed belief of morbid origin, not culturally shared
    2. Content - type
    3. Single/multiple
    4. Elaborated
    5. Systematized
    6. Primary/secondary

7. Mood congruity
8. Acting out
9. Affect associated with
10. Special types

- Possession: obsession, thought alienation [10]

PERCEPTION

conscious awareness of elements in the environment by the mental processing of sensory stimuli.[4]

- Which modality: vision, hearing, smell, taste, touch
- Any special variety – Functional hallucination, reflex hallucination, Extracampine hallucination, Autoscopy.
- Eg: auditory hallucination
  - Verbal / nonverbal
  - Continuous / intermittent
  - Single voice/ multiple voice
  - Familiar / stranger
  - Male/ female
  - Pleasant / unpleasant
  - 1st person / 2nd person / 3rd person
  - Content – threatening, commanding, derogatory, commenting
  - Pt's response to hallucination
  - Diurnal variation – Hypnogogic / hypnopompic
  - Mood congruent / incongruent

HIGHER MENTAL FUNCTION

- **Cognition** - Mental process of knowing and becoming aware[4]
- **Confusion** - Disturbances of consciousness manifested by a disordered orientation in relation to time, place, or person[4]

- **ATTENTION AND CONCENTRATION**
  - Attention - the aspect of consciousness that relates to the amount of effort exerted in focusing on certain aspects of an experience, activity, or task.[4]
  - Concentration is the ability to maintain attention to specific stimuli over an extended period. The ability to maintain focus on the task at hand [4]
    - Serial subtraction – in increasing difficulty
      * 20-1 → 20 to 0 in 15 secs
      * 40-3 → 40, 37, 34, 31, etc in 60 secs
      * 100-7 → 100, 93, 86, 79, etc in 120 secs
    - Reversal of days of week - Reversal of months of year
    - Digit span (Digit forwards/ backwards)[14] maximum of 2 trials [13]

Item	Check if correct
3-7	_____
2-4-9	_____
8-5-2-7	_____
2-9-6-8-3	_____
5-7-1-9-4-6	_____
8-1-5-9-3-6-2	_____
3-9-8-2-5-1-4-7	_____
7-2-8-5-4-6-7-3-9	_____

- **ORIENTATION** - State of awareness of oneself and one's surroundings in terms of time, place, and person.

  Disorientation - Confusion; impairment of awareness of time, place, & person[4]

  Confusion - Disturbances of consciousness manifested by a disordered orientation in relation to time, place, or person. [4]

  Time ( )/Place ( )/Person ( )

  Time: [14]

  1. Approximately what time of the day is it?
  2. Is it morning, afternoon, evening or night?
  3. Approximately how long is it since you had your breakfast/lunch tea/dinner? (OR) Approximately how long have I been talking to you?
  4. What is the day today?
  5. What is the date (month, month, and year) today?

  Place: [14]

  1. What place is this?
  2. Is this a school, office, hospital, restaurant etc?

  Person: [14]

  1. Orientation to self is tested by asking the identity of the patient.
  2. Inquiring about the identity of the patient's relatives or family members.

- **MEMORY:** Mental process that allows the individual to store information for last recall (9). Process whereby what is experienced or learned is established as a record in the CNS (Registration)

where it persists with available degree of permanence (Retention) and can be recollected or retrieved from storage at will (Recall). [4]

- **Immediate** - Reproduction, recognition and recall of perceived material within seconds after presentation,[3] Digit span test. [14]
- **Recent** - Recall of events over the past few days. [3] Ability to learn new material and to retrieve that material after an interval of minutes, hours or days. [14]

  1. Address Test. An address consisting of about 4-5 facts that is not known to the patient is slowly read to the patient after instructing him to attend to the examiner. He is engaged in conversation (to avoid rehearsal) and the response is noted verbatim. Recall is asked for after 3-5 minutes. [13]
  2. Asking the patient to recall events in the last 24 hours e.g., details of the time and amount in a meal, visitors to the hospital from an inpatient. Responses given by the patient should be noted of any cross-checked from reliable source. [13]

- **Remote** - Reproduction, recognition, or recall of experiences or information that was experienced in the distant past.[3] Four to Five facts may be asked that are relevant to the patients background and answers should be cross checked. [13]

  i) date of birth or age
  ii) number of children
  iii) names and number of family members
  iv) time since marriage of death or any family member
  v) Year of completing education.

- **INTELLIGENCE:** Capacity for learning and ability to recall, to integrate constructively, and to apply what one has learned; the capacity to understand and to think rationally. [4] It is the ability to think logically, act rationally and deal effectively with environment. [5]

  - **General fund of knowledge**[14]

  1. How many weeks are in a year?
  2. Why do people have lungs?
  3. Why are light coloured clothes cooler in the summer than dark coloured clothes?
  4. What causes rust?

  For literates[13]

  1. Name of Prime Minister
  2. 5 river, cities or states
  3. Capitals of countries
  4. Current events (major)

  For Illiterates[13]

  1. Seasons
  2. Crops of fruits growing particular seasons
  3. Prices of food grains or food items
  4. Prices of land

- **Arithmetic skill**[14]

  Describe the patient's adequacy in performance and types of errors made on the following types of calculations:

  1. Verbal rote examples:
     a. Addition (4 + 6)
     b. Subtraction (8 – 5)
     c. Multiplication (2 × 8)
     d. Division (56 ÷ 8)
  2. Verbal complex examples:
     a. Addition (14 + 17)
     b. Subtraction (43 – 38)
     c. Multiplication (21 × 5)
     d. Division (128 ÷ 8)

  The following questions may be asked. Time limits: Question 1 to 3 is 15 secs, Question 4 & 5 is 30 secs. [13]

  1. How much is 4 rupees and 5 Rupees?
  2. I borrowed 6 rupees from a friend and returned 2 rupees, how much do I still owe to him?
  3. If a man buys cloth for 12 rupees and gives a shopkeeper 20 rupees; how much change would he get back?
  4. How many pencils can you buy for 2 rupees if one pencil costs quarter of a rupee (on 25 paise)?
  5. If 18 boys are divided into groups of 6, how many groups will there be?

  Correct answers: 1)9, 2)4, 3)9, 4)8, 5)3

  - **Comprehension**[14]

  1. Patient's response to pointing commands: Ask patient to point to one, two, three, then four room objects or body parts in sequence. Record adequacy of performance.
  2. Patient's response to yes-no questions: (e.g., "Is it raining today?" or "Is Abdul Kalam still president?")

- **ABSTRACT THINKING:** Thinking characterized

by the ability to grasp the essentials of a whole, to break a whole into its parts, and to discern common properties. To think symbolically. [4]

- Similarities /Dissimilarities
  - Concrete thinking - Thinking characterized by actual things, events, and immediate experience rather than by abstraction[4]
    - Q: What is the similarity between a table and a chair?
    - A: Both are of wood.
  - Over abstraction - Thinking characterised by excessive manifestation of a concept beyond the point of relevance. The problem at hand looses its value and remain unsolved.
    - Q: What is the similarity between a table and a chair?
    - A: Number of electrons of an atom of a molecule in wood of chair and table are equal.
  - Similarities – other examples[13]
    - Orange - Banana (fruits)
    - Dog - Lion (animals)
    - Eye - ear (sense organs)
    - North - west (directions)
    - Table - chair (items of furniture)
  - Differences being an easier task are always presented before similarities - Other examples: [13]
    - Stone - Potato (not edible - edible/hard-soft)
    - Fly - Butterfly (small-large/not colourful-colourful)
    - Cinema - Radio (audio-visual-audio)
    - Iron - Silver (heavy-light-dull-bright)
    - Praise - Punishment (Positive-negative/ pleasant-unpleasant)
- Proverb testing
  - The patient is asked the following questions
    a. Whether he knows what a proverb is
    b. An example of a proverb and what is means

  If it is clear that the patient has the concept of a proverb the following may be asked

  1. Slow and steady wins the race
  2. A barking dog never bites
  3. As you sow, so shall you reap
  4. All that glitters is not gold or all that is white is not milk

  The response of patient is to be noted verbatim and judged to be correct/incorrect.

- **JUDGEMENT**: Mental act of comparing or evaluating choices within the framework of a given set of values for the purpose of electing a course of action. [4]
  - Personal - Judgment is assessed by inquiries about the patient's future plans. [13]
  - Social - Judgment is assessed by observing behaviour in social situations.[13]
  - Test - [13]
    1. Fire problem: If the house in which you are catches fire, what is the first thing you will do? (Correct answer – try to put if off with water)
    2. Letter problem: If when you are walking on the roadside you see a stamped and sealed envelope with an address on it which someone had dropped, what will you do? (Correct answer post it in a letter box, or give it to the post man)
- **INSIGHT:** Conscious recognition of one's own condition. In psychiatry, it refers to the conscious awareness and understanding of one's own psychodynamics and symptoms of maladaptive behaviour. [2]

  Grading of Insight: (3)

  - **Grade-1** Complete denial of illness.
  - **Grade-2** Slight awareness of being sick and needing help, but denying at the same time.
  - **Grade-3** Awareness of being sick, but it is wrongly attributed to external or physical **factors.**
  - **Grade-4** Awareness of being sick, but attributes to something unknown in self.
  - **Grade-5** Intellectual insight- awareness of being ill and that the symptoms/ failures in social adjustment are due to own particular irrational feelings/ thoughts; yet doesn't apply this knowledge to the current/ future experiences. Knowledge of the reality of a situation without the ability to use that knowledge successfully to effect an adaptive change in behaviour or to master the situation
  - **Grade-6** True emotional insight- it is different from intellectual insight in that the awareness leads to significant basic changes in the future behaviour

Series of questions asked to assess insight: [2]

- Is the patient aware of phenomena that others have observed (e.g. that he is unusually active and elated)?
- If so, does he recognize the phenomena as abnormal (for example, maintaining that his unusual activity and cheerfulness are due to normal high spirits)? [12]
- Do you believe that the experiences that you are having, are symptoms?
- Do you believe that these symptoms are attributable to illness (as opposed to, say, a physical illness or poison administered by enemies)?
- Do you believe that the illness is psychiatric?
- Do you believe that psychiatric treatment might benefit you?
- Will you be willing to accept advice from a doctor regarding your treatment? [5]

DIAGNOSTIC FORMULATION

Psychiatric diagnosis is essentially a way of grouping symptoms and signs into certain groups of "illness". The bio-psycho-social approach is essential to the formulation.

The summary should sift the information obtained to produce a brief outline of:[15]

- Introductory comments:
  - Present the salient socio-demographic features of the patient
  - e.g. 'Mrs. R is a 30-year-old married school teacher living with her husband and a 4-year-old son'
- Past history of psychiatric disorder, its treatment and outcome
  - e.g. 'Mrs. R had had similar symptoms soon after her son's birth; she was treated with antidepressant medication and became completely well in about two months'
- Positive medical history of significance
  - e.g. 'The patient was detected to be hypothyroid a year ago and is on treatment'
- Presenting problems:
  - State the main problems excluding irrelevant details
    e.g. 'Over the past two months she has become increasingly depressed, with loss of energy, self-reproaches and self-depreciating ideas'
  - Briefly mention how the patient's life has been affected by the problems
    e.g. 'She has not been going for work and has also been unable to do the housework or take care of her child'
  - Mention events closely related to the onset or exacerbation
    e.g. 'The onset of symptoms was preceded by a medical termination of pregnancy about which patient was very ambivalent'
  - Avoid long lists of minor or transient symptoms and negative findings except those that will help in the differential diagnosis.
- Mental status examination: Mention important findings only. Use labels for psychopathological findings at this stage,
  - E.g. use terms such as 'delusions of guilt', 'third person auditory hallucinations' etc. Details of these findings should have already been described during the detailed presentation prior to the formulation.

Example:

A _____ year old unmarried male driver by occupation with no significant past or family h/o psychiatric illness, presented with illness duration of 10 years which was insidious in onset ,continuous course, Precipitated by death of friend ,characterized by suspiciousness, delusion of reference, delusion of persecution, 3 rd person auditory hallucination, has suicidal ideation with significant socio occupational dysfunction. GPE- Tachycardia, MSE- Irritable, delusion of persecution, poor judgment with absent insight.

DIAGNOSIS

Mention whether confident diagnosis, provisional diagnosis, tentative diagnosis. If diagnosis is not clear, embark on a careful discussion of the possibilities in the order of likelihood,

Differential diagnosis: If there is little doubt about the diagnosis, say so and say why. Do not present an irrelevant differential diagnosis for the sake of giving one, [5] and discuss points in favour of and against each of them.

End the discussion with a conclusion on the most likely diagnosis. If that is not possible at all, mention the major possibilities.

According to ICD – 11 - _____

According to DSM 5 - _____

MANAGEMENT PLAN

Locus, Focus, Modus

a. **Immediate management plans**

Locus: Is the patient to be treated as an inpatient or outpatient? If as an inpatient, why?

Immediate Focus: Management of suicide risk/violence - specify management type/ justification/dosage/route/expected response/ side effects and their managements.

b. **Further investigations Focus:** In each case specify which procedure/tests you would organize and its justification

- Includes information from key relatives/ employer/teachers
- Review of past case records
- Laboratory investigations
- Psychometry

c. **Long-term management plans: Modus**

Biological	Medication - type/dosage/duration
Psychological	Psychotherapy - indications/type/focus
Social	Involvement of the family/rehabilitation measure

Prognosis: This should not be a general pronouncement, based merely on the type of disorder. Discuss pertaining to each patient.

- good e.g. acute onset; affective symptoms
- poor e.g. poor drug compliance in the past; poor social support

Prognosis can also be described as

- **Short term** e.g. Chances of recovery from the present episode is good with antidepressant treatment
- **Long term** e.g. Risk of relapse and recurrence is high because of the significant marital discord and patient's reluctance to take medicines on a long-term basis.

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Nil

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This work was carried out in collaboration among all authors. All authors have read and approved the final manuscript.

CONSENT

As per the ICMR guidelines, the informed written consent has been obtained and preserved by the corresponding author.

ETHICAL APPROVAL

As per the National standards, the ethical approval letter/ certificate from local IEC has been obtained and preserved by the authors.

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