Basics in Psychiatry, Clinical Examination and Psychopathology

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By

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FOREWORD

The most crucial aspect of psychiatric evaluation is eliciting a comprehensive history and assessing the varied expressions of the functioning of the mind. Unfortunately, over the years, the training to acquire the art and skills of this process has not received due attention. Dr. John Mathai has filled this gap with this book which carefully details each aspect of the process of clinical evaluation in psychiatric practice. Unlike other medical disciplines, in psychiatry, the clinician must largely rely on the patient's description of their lived, subjective experiences. Eliciting and delineating psychopathological experiences carefully is a critical step in arriving at a diagnosis. The entire process is greatly enriched when it occurs on the foundation of a strong therapeutic alliance. Dr. John Mathai has addressed all these aspects exhaustively and with much clarity. This is a timely and important contribution which can enhance the skills of trainees and benefit them.

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PREFACE

Clinical Examination and Clinical Psychopathology are the basics of Clinical Psychiatry. The excellent and available books on these subjects are massive, voluminous textbooks that are by and large difficult for postgraduates or novices in psychiatry to comprehend. Although knowledge of clinical examination and clinical psychopathology is essential for good clinical practice, inadequate emphasis has been given to training postgraduate doctors in such fundamental subjects. This book is written based mainly on my lectures for postgraduate doctors in psychiatry from 1984 to 2023. I have tried to simplify the various aspects of the subjects, avoided complexity and speculations, and been lucid, brief, and concise.

This book is meant only as an introduction to the basics of clinical psychiatry for novices and early career practitioners. Also, it is not a substitute for the notable and acclaimed books on clinical examination or clinical and descriptive psychopathology. It is my sincere hope that this book will empower readers with the knowledge of the fundamentals of psychiatry which in turn would motivate and equip them to read and understand more advanced literature on the topic. The clinical skills and knowledge in clinical psychopathology that this book seeks to provide any trainee with will not only serve as the fundamental building blocks of their grasp of the subject but may also contribute to their success in their postgraduate final clinical examinations.

The concise nature of the book is designed to help doctors in related disciplines as well to understand and appreciate the basics of the clinical practice of psychiatry. Furthermore, I hope the book helps to enlighten healthcare professionals about the poorly understood field of psychiatry and deepen their basic understanding of its relevance.

Dr. John Mathai Panickacheril.

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Throughout my long teaching career, I had a deep-seated desire to write down some of my learning which could be useful for the next generation of trainees in psychiatry. I am grateful to the Almighty for giving me enough health, time, and motivation to complete this book. I am indebted to all my patients over the years who recounted their experiences of the manifold phenomena of psychiatric disorders and thus, taught me what I know and made me aware of how limited my knowledge in psychiatry is. I am thankful to my students who provided many insights during our learning journey together. I owe a debt of gratitude to some of my colleagues and friends for their respect for my abilities as a teacher and for motivating me to write this book.

As I embark on the publication of my first book, I am grateful for the support I have received from my family. With all the requests I made for their knowledge and time, there was always someone who walked along with me to make this book and my cherished wish come true. Many have helped me in the preparation of the manuscript and publication of the book. Without their help and support this would not have happened.

I acknowledge my special gratitude to Dr. John Alexander Panickacheril (University of Western Australia) and Mr. John Winnie for their invaluable help in editing and preparing this manuscript. I wish to thank Dr. John P John (NIMHANS) for the substantial help rendered by him. I also wish to thank Dr. John Roy Panickacheril, Dr. Pavithra P Rao, Mrs. Merlin Kurian, Dr. Sneha John, Mr. Brijesh John and Dr. R. Raguram for their comments and support.

Dr. John Mathai Panickacheril.

PART I.

CLINICAL EXAMINATION IN PSYCHIATRY

CHAPTER 1

PSYCHIATRIC INTERVIEW

The most thorough clinical evaluation in psychiatry includes the psychiatric clinical interview, physical examination, laboratory investigations, neurological investigations that include electrical, structural, and functional brain imaging, psychological and neuropsychological tests, use of scales for assessment of psychopathology, and use of structured or semi-structured diagnostic interview schedules. During the clinical examination, we gather relevant, essential, reliable data (information) and record them in proper order. The entire procedure is geared at reaching a confident/definite clinical diagnosis or at least a provisional/tentative clinical diagnosis based on ICD-10/11/ DSM- 5 and formulating a complete initial comprehensive treatment plan. The length, nature, and order of evaluation depend on the clinical settings, and they are modified accordingly.

The psychiatric interview is a purposeful encounter between the doctor and the patient to gather essential relevant data for diagnosis and management based on a clear understanding of the psychopathology and to develop and maintain a reasonably positive doctor-patient professional relationship (Sadock et al. 2017, Hales et al. 2015, Tasman et al. 2011, Hales et al. 2011, Betts & Kenwood 1992). The four essential tasks of a clinical interview are (1) to obtain a psychiatric database (2) to arrive at a diagnosis (3) to negotiate a treatment plan and (4) to build a therapeutic professional relationship (Hales et al. 2011). The psychiatric interview may appear like a casual conversation but as a matter of fact, it is an extremely precise diagnostic tool. It is a skill founded on explicit and extensive knowledge of human behaviour and clinical psychopathology. Recent advances in medical technology including brain imaging help psychiatrists to make more accurate diagnoses and to develop more specific treatment plans. However, they cannot replace or supplant the importance of traditional psychiatric interviews. Psychiatric interview remains the cornerstone of clinical evaluation in psychiatry despite the tremendous advances in technology in medicine. Clinical examination essentially includes a psychiatric interview (history and mental status examination) and physical examination. In clinical practice, in an ideal setting (inpatient setting), this

will take between thirty minutes to one hour. Generally, in an examination setting, the candidate (postgraduate student) must complete the clinical examination in no more than 45 minutes. The clinical examination is modified in other settings such as the outpatient department, general medical/surgical department, emergency department, community centre, and primary care setting depending on the requirements and practical constraints.

The doctor must always know that the patient invariably expects relief of suffering and remedy for the disorders and the doctor is expected to provide both. Hope of relief is the motivation for exposing himself/herself to the doctor. Respect for the patient as well as empathy and strict adherence to principles of confidentiality are therefore important. Any kind of exploitation or deception based on the data collected is unethical. By and large, it is always better to interview the patient before other informants are interviewed whenever feasible.

It is extremely important to get formal training in interviewing techniques. Doctors who are not trained in interviewing skills tend to fail to elicit easily available information, fail to establish appropriate doctor-patient professional relationships and prematurely narrow down or lose the focus of the inquiry. With formal training, the doctor learns to interview the patient in a systematic, logical, and structured method using appropriate language. The training initially imparts a uniform proper method of interviewing to all trainees. Subsequently, the trained doctor can modify and shape the style of interviewing to a suitable and comfortable method for his personality and preferred methods of clinical practice without compromising the fundamental principles. Good interviewing skills are important in all branches of medicine particularly in psychiatry because a reliable history and mental status examination is inevitable for diagnosis and management. In psychiatry, the doctor depends almost always entirely on the clinical interview for diagnosis. During the interview, the doctor attempts to elicit accurate information as completely as possible and to remain uncluttered by misinformation and misunderstandings derived from failure to understand the language and emotions of the patient. The ability to properly communicate and understand others is important in the conduct of a clinical interview. We must be aware of the truth that any amount of knowledge in psychiatry is of little use if we do not know how to carry out a proper clinical interview and elicit reliable and accurate clinical data. It is important to get trained in psychiatric interview techniques in the early phase of postgraduate education in psychiatry because it is very difficult to unlearn and get rid of the bad techniques that yield unreliable and incomplete data. For the sake of

convenience, the psychiatric interview may be discussed under the following headlines: the prerequisites and preparation for the interview, the process of the interview, and the contents/elements of the interview (Sadock et al. 2017, Betts & Wood 1992).

[I]. PREREQUISITES AND PREPARATIONS:

The ideal interview setting is one which provides a pleasant atmosphere that is reasonably comfortable, private, and free from outside distractions. Such a setting should not only provide the physical necessities but should also convey that the patient is cared for and safe. The interview room should be relatively soundproof. The doctor's chair and the patient's chair may be of equal size so that the interviewer does not tower over the patient. It is generally agreed that the doctor and the patient may be seated 4 to 6 feet apart. The psychiatrist should dress professionally and be well-groomed. There should be minimal distractions. Unless there is an emergency matter, there should be no telephone or beeper interruptions during the interview. The patient should realize that the time is set aside exclusively for him (Sadock et al. 2017, Hales et al. 2015, Sadock et al. 2009, Tasman et al. 2004).

The doctor should have an adequate understanding of human behaviour and explicit knowledge of clinical psychopathology (manifestations/signs and symptoms) and psychiatric disorders. In addition to this, he must have enough training in interviewing techniques and principles.

[II]. PROCESS OF INTERVIEW:

The process of clinical psychiatric interviews can be divided into three phases consisting of six parts.

A. Initial Phase (Opening Phase):
   1. The Beginning.
   2. Orienting the patient.
B. Middle Phase (Body of Interview):
   3. History Taking.
   4. MSE.
C. Concluding Phase (Closing Phase):
   5. The Exposition.
   6. The Termination.

[A]. INITIAL (OPENING) PHASE OF INTERVIEW:

The contents/elements of this phase include the beginning of the clinical interview and orienting the patient to the same. In the beginning, the doctor greets the patient, indicates where he is to be seated and introduces himself. He adopts a posture which conveys friendliness and interest. During the orienting process, he explains to the patient the nature and purposes of the interview, the time available for the same, the need to record essential data, the degree of confidentiality, and the subsequent necessary interviews.

[B]. MIDDLE PHASE OF INTERVIEW:

This phase is the body of the clinical interview during which the doctor elicits the clinical history and performs the mental status examination. The doctor should always begin with open-ended questions which cannot be answered by 'yes' or 'no' to draw the patient out and elicit the presenting symptoms. The doctor must make sure that he has elicited all the complaints. Recapping these symptoms may be helpful in certain situations before the examiner starts the rest of the interview. It is perhaps helpful to allow the patient to talk freely without directions for a few minutes, in the beginning. During this time, the doctor should be listening and planning the strategies for the rest of the interview, particularly in terms of degree of control and pacing. For example, the doctor will have strategies for containing an over-talkative patient, drawing out a shy and defensive patient, and the relative amount of time available on different themes and tasks in a patient with multiple complaints. After a few minutes of non-directive interview, the doctor will be more active and exert optimum control over the entire process to elicit the essential and accurate data for arriving at a diagnostic formulation and developing a management plan. Always the doctor starts with an open-ended screening question to begin a new topic. He observes for verbal and nonverbal clues expressed by the patient. Then he goes for initial clarifications and asks for explanations and examples when necessary. This is followed by further clarifications with specific details to elicit a phenomenon with great precision and accuracy and get the exact details. Open-ended to closed questions, optimum control, precision, and accuracy are the essential requirements for this phase of the interview.

Always start a new topic with an open-ended question and finish with closed questions. Introduce the new topic before you ask the open-ended question so that the patient understands the same. Brief recapping may be useful in certain contexts. Clarify the responses to your initial question. Pursue the

topic and complete the same before you turn to the new information emerging from the answers that are not related to the topic under consideration.

[C]. CONCLUDING PHASE OF INTERVIEW:

This phase includes the exposition and termination. During the exposition, the doctor explains in simple language what is wrong with the patient and the plans for management. This should be done at the level of understanding of the patient. The doctor then checks whether the patient understood the same. The doctor terminates the interview by indicating that it is over if there is no doubt and gives a date for follow-up.

[III]. CONTENT OF INTERVIEW:

The content of the interview includes essentially all factors covered under clinical history and mental status examination. This will include broadly the disorder-related data and the person-related data. The contents of psychiatric interviews are discussed in detail in the chapters on clinical history and mental status examination (Chapters 2 and 3).

TECHNIQUES OF INTERVIEW:

Verbal and non-verbal communication is crucial in psychiatric interviews. The core interviewing techniques of communication can be classified into three overlapping types namely directive, nondirective and nonspecific techniques (Hales et al. 2015). The questions used in psychiatric interviews belong to three different kinds. They are well known as the screening questions (general probes), the initial clarifications (further probes), and the further clarifications (specific probes) (Betts & Kenwood 1972, SCAN 1992). Questions from structured/semi-structured diagnostic clinical interviews such as SCAN, SCID, DIS and others can be appropriately selected and judiciously used in clinical psychiatric interviews. Moving from open-ended to closed questions is a general principle. Leading questions, lengthy questions, double-barrel questions, multiple-choice questions, and single-response questions are avoided in most parts of clinical interviews. The use of leading questions, multiple-choice questions, and single-response questions is rarely required and should be limited to specific clinical situations. The doctor should refrain from excessive unwanted questions. Expert authors have documented facilitative techniques and messages such as open-ended questions, positive facilitative body language, positive reinforcement, appropriate silence and meaningful pauses, timely interpretations, recapitulations, reflections, checklist questions,

"I want" messages, smooth transitions, and rare appropriate self-disclosures (Hales et al. 2015, Sadock et al. 2017, Tasman et al. 2004). Examples of documented obstructive techniques and messages are excessive direct questions, run-on questions, pre-emptive topic shifts and inappropriate switching, premature advice, false reassurances, putting down questions, trapping the patient with his own words, "you are bad" statements, confrontations, use of psychiatric jargons, judgmental questions, actions without explanations, non-verbal disapproval, and non-verbal messages of resentment. The nonspecific facilitative techniques include good professional alliance, attentive genuine listening, neutrality, and ensured confidentiality (Tasman et al. 2004, Hales et al. 2015, Sadock et al. 2017). The doctor should be trained to use more facilitative techniques of communication and avoid and discourage the use of detrimental obstructive techniques.

CHAPTER 2

CLINICAL HISTORY

Eliciting reliable and comprehensive history from the patient and if necessary, from other informed sources are essential clinical practices for accurate diagnosis and formulating effective treatment plans. Clinical history in psychiatry is not entirely different from ones that are taken in other divisions of medicine. In addition to gathering the concrete clinical factual data related to psychiatric and medical symptoms/disorders/diseases essential for diagnosis and management, the psychiatrist attempts to derive from the history the elusive picture of the personality traits and unique background of his patient. This includes his strengths and weaknesses as well as his family and social backgrounds. The complete psychiatric history provides insight into the nature of the psychiatric and co-morbid medical disorders, the patient's temperament, character, interpersonal relationships, family and social background and social support system. In many instances, eliciting a comprehensive developmental history from the earliest formative years is advisable. In short, a complete psychiatric history is a record of a patient's psychiatric and medical symptoms and his personal and social life. It gives us information about disorders (diseases), illnesses (personal experiences), and sickness (social consequences) of the patient (Sadock et al. 2017, Hales et al. 2015, Hales et al. 2011, David et al. 2009, Tasman et al. 2008, 2004, APA 2004, Kay et al. 2000, Betts & Kenwood 1992, Meyer-Gross et al. 1969).

Like in other branches of medicine, a reliable history is essential for a complete diagnosis in psychiatry. It is commonly believed that psychiatrists arrive at diagnosis entirely depending on clinical history and in other branches of medicine, they do so mostly depend on the clinical examination. This erroneous belief is held because psychiatric interview is the one and only tool for history taking and mental status examination in psychiatry. However, as a matter of fact, in all branches of medicine for an accurate and refined diagnosis, history, clinical examination and investigations are necessary. We often make use of reliable data from history to complete or perfect a diagnosis. For example, in a patient with CVA, a doctor can arrive at functional and anatomical diagnosis depending only on clinical examination

findings. However, the data from history are often essential to make further refinement of the diagnosis at pathological and etiological levels like infarct/haemorrhage and hypertension to complete the diagnosis for proper management. In many instances, the investigation reports may or may not confirm the diagnosis. In psychiatry, a doctor can also make a diagnosis at the syndrome level like mania, depression or psychosis depending on only examination findings. Nonetheless, reliable data from history are necessary to complete the diagnosis.

Assessment of the reliability of data elicited from history is therefore vital, especially in psychiatry, because we use such data to refine our diagnosis. Quite often in the practice of psychiatry, the patient may not be in a clinical state to give reliable history. We may have to depend on other sources for the same. The reliability of information should always be assessed irrespective of whether it is from the patient or other sources. If the information is reliable the data can be used for diagnosis based on international criteria such as ICD-10/11 and DSM 5. The credibility of the informant, his contact with the patient during the disorder, his ability to give continuous (complete) history, and the consistency of the information passed on to you are the factors that help us to conclude whether the information is reliable or not. In case the reliability is uncertain, the doctor would seek corroboration of the information from collateral reliable sources. These factors could be kept in memory as the five C factors of reliability (credibility, contact, continuity, consistency and corroboration). If the history is not reliable or incomplete, the doctor should get information from other reliable sources. It is also important to find out whether the information is adequate for diagnosis and/or management. Genuineness of interest, intimacy, relationship, and motives towards the patient are perhaps the best predictors of the credibility of the informant in this context unless otherwise proved. Levels of education, class, profession, and blood relationship need not necessarily be predictive of credibility. Adequate contact with the patient during the patient's disorder is an essential prerequisite for getting a reliable history. In general, a discontinuous history indicates a poor degree of reliability. Consistency of information is perhaps the most dependable factor indicating the reliability of the clinical history. Consistency should be tested during psychiatric interviews by intentionally repeating random questions without the patient's (informant's) awareness of the same. This should be a regular practice to ensure that you are not deceived or distorted. Whenever possible, information may be gathered from collateral sources to find out whether it corroborates well with the information from the primary source. Such corroboration indicates good reliability. We must consider all these factors and not just one or two of

them before we decide on the reliability of data from clinical history. We mostly tend to collate history obtained from different sources and mix them up, especially when we are busy. It is important to make sure not to collate history from different sources unless they are the same. When there are major or minor contradictions in the data from two different sources, the data should be recorded separately mentioning clearly the source from which you elicited them.

Clinical history should include vital data (identification and socio-demographic data of relevance), presenting symptoms (present complaints, chief symptoms, chief complaints), history of present illness (history of present psychiatric and medical disorders), past history (psychiatric and medical history in the past), family history, personal history (developmental, personal, and social history) and premorbid personality/inter morbid personality (Sadock et al. 2017, Hales et al. 2015, Hales et al. 2011, Tasman et al. 2004, Gelder et al. 1996, Betts & Kenwood 1992, Meyer-Gross et al. 1969).

VITAL DATA:

The vital data essentially will include the data necessary for the identification of the patient as well as the socio-demographic data of clinical relevance in terms of diagnosis, investigations, treatment, and prognosis. The following are often recorded essential data for identification: name of the patient, identifying codes allotted-like outpatient/inpatient/hospital numbers, name of father/mother/spouse/others if required, residential/permanent address, email id, phone numbers, and source of referral.

The socio-demographic data are relevant in terms of diagnosis, management, and prognosis. For example, data such as age and gender are often relevant for diagnosis, management, and prognosis. On the contrary, education, occupation, and religion may not directly help us in diagnosis but are important, particularly for psychotherapeutic management and may be in terms of prognosis. The relevance of the socio-demographic data depends on the clinical situation. For example, the location of residence and distance from the hospital may be helpful for you to decide on treatment settings and frequency of follow-up visits in certain circumstances. The often-recorded socio-demographic data include the age of the patient (date of birth), sex/gender, education, occupation, marital status, type of family, religion, average monthly income, sources of income, socio-economic class, location of residence (distance from hospital), language used for interview, use of interpreter and finally date and time of examination. The record of the date

and time of clinical examination may assume great importance in certain clinical disorders like delirium, substance use disorders, and acute and transient psychotic disorders. Record of date and time of examination always have of course legal implications.

PRESENTING SYMPTOMS:

Whenever possible, record the symptoms or complaints reported by the patient/informant in their language as such. It is important to find what exactly the informant means by the symptoms. Make it a point to ensure that the meaning of the terms is accurately recorded. It is important to keep in mind the fact that no language is sufficiently competent to express explicitly the inner experiences of a person, especially so when the person is in distress. One should also remember that the informants and the doctors are not language experts. Always make special efforts to ascertain the duration of each symptom. In certain situations, it may be difficult to evaluate the exact onset of the symptoms reported. Record the symptoms in chronological order. When there are multiple symptoms, select and record the chief symptoms. Discourage the informant from using jargon to replace symptoms. Always try to avoid pseudo-medical terms. Often, the carefully elicited presenting symptoms with duration can give significant clues towards diagnosis and can give early directions in the history of the present illness. (Example: Sleeplessness- 8 years, Irrelevant Talk- 7 years, Talk to Self- 5 years, Tendency to Wander- 2 years, and Tendency to Assault- 6 months).

HISTORY OF PRESENT ILLNESS:

History of Present Illness (HOPI) is the detailed coherent account of the current disorder/disorders in chronological order from the time of onset to the date of examination. There is no general/universal scheme for eliciting present history in psychiatry. The scheme will depend upon the symptoms presented and the disorders. The data are collected and recorded. HOPI is the most important part of the clinical history in terms of diagnosis, management, and prognosis. Like in other branches of medicine, HOPI is the factual disorder-related clinical data. Elicitation of HOPI depends on the extent of knowledge of the doctor about the disorders and his skills and clinical experience. This means that there are always provisions for all of us for sharpening and improving our HOPI, and this efficiency does not end with acquiring postgraduate degrees in psychiatry or with decades of clinical experience. Although there is no established universal scheme, the

HOPI should at least include details about the following factors of the disorders:

1. Age of Onset.
2. Mode of Onset.
3. Precipitating Factors.
4. Course of the Disorder.
5. Nature of the Symptoms.
6. Associated Symptoms/Checklist Symptoms/Review of Symptoms.
7. Negative History.
8. Biological/Vegetative Functions.
9. Socio-Occupational Functions/Impact on Social, Occupational, and Activities of Daily Life.
10. Treatment History and Current Medicines.
11. Current Other Medical Diseases and Medicines.
12. Other Relevant Factors if any.

Three relevant aspects of the onset of the disorder should be elicited. They are the age of onset, the mode of onset and the presence or absence of significant psychosocial or physical precipitating factors at the time of onset or before onset. The exact age of onset need not necessarily be evident always from the reported presenting symptoms. Therefore, the doctor may have to make efforts to elicit the age of onset especially if the onset is gradual/indefinite and the duration is several years. The mode of onset may be sudden or gradual and sometimes indefinite particularly in patients with a long duration of continuous disorders. Acute onset is defined as within 2 weeks and abrupt onset as within 48 hours in the context of Acute and Transient Psychotic Disorders in ICD-10. The psychotic symptoms are obvious (not necessarily the peak) within the stipulated period in ATPD. Precipitating factors could be physical distress such as disease and disability or psychosocial distress such as adverse life events and conflicts. Most often the essential elements of stress include one or more of loss, change, and distress. It could be acute stress or chronic stress. It can at times be exceptional (catastrophic) stress.

The response to stress is an integral aspect of human existence. There are at least three conceptualizations of stress: as a stimulus (assumption of an external factor), as a response (located within the individual) (Selye 1956), and as an interaction (Lazarus and Folkman 1984). Stress is the interaction between the person and the environment that is appraised by the person as taxing or exceeding his resources and endangering his well-being. However, the doctor should be aware of the truth that the lay meanings of stress are

significantly different from their psychiatric concepts, and patients and informants tend to often attribute the onset of disorders to stress. The doctor should get the descriptions of the events to arrive at proper conclusions regarding the existence of significant stress. Stress has been defined in ICD-10 and DSM-5 under criteria dealing with stress-related disorders. Here, stress is conceptualized as assumed external events. Significant stress is conceived as events that are stressful for most people in similar circumstances within the culture of the concerned person according to ICD-10. Events that are stressful for an average person in similar circumstances with similar sociocultural values and similar experiences of the concerned person are significant stress in DSM-5. Catastrophic or exceptionally threatening stress is one that is likely to cause pervasive distress in almost anyone according to ICD-10. Witnessing or learning about an actual or threatened death, serious injury or damage to physical integrity is catastrophic stress according to DSM-5. ICD-11 refers to two kinds of stress, both of which may be prolonged or repetitive. They are stressful or traumatic events or adverse experiences and stressors of extremely threatening nature or horrific nature (potentially traumatic events). Significant stress may contribute to the occurrence, onset, exacerbation, relapse, recurrence, precipitation and perpetuation of psychiatric disorders in general and particularly stress-related (stress-specific) disorders and anxiety disorders.

A group of disorders are designated as stress-related (stress-specific) disorders in DSM-5, ICD 10 and ICD-11. The presence of significant stress is one of the criteria for diagnosis of such disorders. The criteria for the onset of the symptoms of the disorders are specified in ICD-10 and DSM-5. In acute stress reaction (F43.0), the onset is within a few minutes, if not immediately, of exceptional stress. In adjustment disorder (F43.2), the onset is within one month. In PTSD (F43.1), the onset is within six months of the catastrophic stress. It is possible to have delayed onset much longer than six months in certain PTSD. In DSM-5, the onset is immediately after exceptional stress in acute stress disorder (308.3). The onset for adjustment disorders in DSM-5 (309) is within three months of the stress. In PTSD (309.81) like in ICD 10, the onset is within six months but there could be further delay in the onset. Adjustment disorder (6B43) usually emerges within a month of the stressor according to ICD-11. The various common stressors include conjugal stress, parenting stress, interpersonal stress, occupational stress, living circumstances-related stress, financial stress, developmental stress, family stress, physical disease, injury, accidents, and catastrophic stress. The age of onset, the nature of onset and the presence of significant stress may give us clinical clues towards proper diagnosis and of course, they are generally important for management and outcome.

The course of the psychiatric disorders may be characteristically different, and the course may vary within the same disorder depending on several known and unknown factors including prognostic clinical factors and treatment response. The course may be described as continuous (continuous and progressive, continuous with relapses and remissions, continuous with stable deficits) episodic, (single episodes, multiple episodes, episodes with recovery, episodes with remission, episodes with unstable residual deficits, episodes with stable deficits, episodes with progressive deficits), paroxysmal, in remission (partial/complete), exacerbation, relapse, recurrence, and recovery. It is important to get a history of 'change points' in the course of the disorder indicating the development of medical and psychiatric comorbidity and potential complications. The course of the disorder is important for diagnosis, management and outcome.

History regarding the nature of symptoms, significantly associated symptoms, and negative history are perhaps the most pertinent aspects of HOPI for a diagnosis like in other branches of medicine. The quality of HOPI elicited will depend on the disorders of the patient, the depth of knowledge of the doctor, and his experience in examining such patients earlier. There is always provision for improvement of the quality of HOPI even after several decades of clinical experience bearing in mind the updated revisions in diagnostic guidelines, the advances in clinical psychiatry and accumulated knowledge and experience. Like in other branches of medicine, the clinical finer details regarding the nature of symptoms will give the doctor clues about potential reasonable diagnostic possibilities. Keeping such possibilities in mind the doctor gets details about significant associated symptoms. He may use the checklist of symptoms or review of systems method to collect accurately and comprehensively the significant associated symptoms. The absence of pertinent associated symptoms will be recorded as a negative history ruling out certain diagnostic categories. The doctor must know how to get details regarding the nature of symptoms such as sleeplessness, irritability, sadness, tension, worries, excessive happiness, repeated thoughts, repeated actions, talking to self, laughing to self, suspiciousness, problems in thinking, memory problems and the like. This is almost analogous to eliciting the nature of chest pain, headache, vomiting and the like. This skill improves with knowledge regarding the diagnostic possibilities. For example, the doctor must first know the aspects of sleeplessness that are characteristic of depressive disorders, anxiety disorders, bipolar disorders, psychotic disorders, organic mental disorders, and primary sleep disorders to elicit a good history regarding the nature of sleeplessness and go further on to the relevant associated symptoms and

negative history. The doctor must acquire over some time, the knowledge, skills and attitude to elicit properly such aspects of HOPI.

It is pertinent to get a proper history regarding disturbances in biological functions (sleep, appetite and eating, bowel and bladder functions, and libido) and socio-occupational functions (personal care, occupation and interpersonal relationships) in all patients. A significant majority of psychiatric patients are likely to have symptoms related to such functions and some such symptoms may be particularly characteristic of certain disorders (terminal sleeplessness, reduced need for sleep, loss of appetite with significant reduction of weight, loss of libido). It is important to gather information regarding the social and occupational functions and the activities of daily personal life in all patients. The data about the decline or alterations of such functions would provide us with clues regarding the impact of the disorder and its symptoms on the lives of the patients. Such data sometimes might also indicate the severity and outcome of the disorders.

The doctor should make sure that he gathers other relevant data not mentioned above when relevant. This would include legal issues and legal steps, implications of the disorder, insurance issues, compensation issues, psychological advantages of having symptoms and complications of the disorder such as substance use, suicidal behaviour, homicidal behaviour, destructive behaviour, impulsive acts, dangerous acts, and neglect of self and family.

History of substance use should include the age of first use, reasons (provocations/cues) for first-time use and subsequent uses, quality of first experience on the use and subsequent experiences, frequency, quantity and route of administration, the pattern of use, changes in the pattern of use, a larger quantity of use and effect on experience, longer duration of use and effect on experience, amount of time spent and methods adopted to obtain the substance, persistent unsuccessful desire to control or cut down use, abstinences and reinstatements, craving/strong overpowering desire for substance, loss of control, evidences of tolerance, evidences of withdrawal symptoms, neglect of alternate pleasures and interests in life, persistent failure in social role functioning, persistence of use even after being informed about having medical/psychiatric complications, continuation of use despite having social/interpersonal/psychological significant problems, use in physically hazardous/dangerous/risky situations, use of other substances along with clinical details about each of them, involvement in

drug trafficking, dissocial and illegal activities, and available sources of the substances used.

The extent and intrusiveness of suicidal ideations, suicidal intent and degree of planning should be explored in a non-judgmental way. It is also important to gather the patient's perception of the current protective factors. To gather the history of risk towards deliberate self-harm and suicide, the following data are to be obtained in clinical history: The degree of current suicidal ideas such as no suicidal ideas, passive suicidal ideas (death wishes), active suicidal ideas but for commitments in life (children, family, religious conviction), ambivalent active suicidal ideas despite commitments, active suicidal ideas without plans, and active suicidal ideas with plans are collected. History of previous suicidal attempts and the lethality of attempts in terms of the required medical interventions are gathered. In addition to the above, the doctor should get details about the epidemiological risk factors for suicide, protective factors against suicide, social support system of the patient, and reliability of information passed on to you by the patients. Corroboration of information from other sources may be required in many patients with suicidal risk to avoid incorrect clinical judgment of the suicidal risk (Castle & Jones 2009).

For risks for homicidal/dangerous/aggressive/destructive behaviour, similar history in terms of current behaviour, previous behaviour, epidemiological risk factors, and reliability of information can be elicited. Neglect of self can be in different forms such as neglect of self-care, hygiene, health, food, medicines, adherence to treatment, financial state, social standing (inappropriate behaviour), and others. The data regarding neglect of others, particularly the family, should be gathered. The data regarding risks towards vulnerability can be collected in terms of vulnerability due to psychiatric symptoms such as positive symptoms, negative symptoms, mood symptoms, anxiety symptoms and cognitive deficits as well as vulnerability due to provocations (Castle & Jones 2009).

The treatment history of the present disorders should include treatment for both psychiatric and medical disorders. This should include medicines, dosage, duration of treatment, response, adverse effects, hospitalization, ECT and other physical methods of treatment, psychosocial therapy, and alternate medical treatment if any. The doctor should gather relevant data regarding the patient's current medical diseases and the medicines and other treatments he has been receiving. Other medical diseases and medicines may have a direct or indirect impact on the current psychiatric syndrome of the patient. It is important to remember that patients with major psychiatric

disorders are more likely to suffer from comorbid medical diseases, have suboptimal access to treatment, and have reduced life expectancy as compared to the general population.

PAST HISTORY:

Past history is the clinical history of psychiatric and other medical disorders in the past meaning that which is not dealt with in HOPI. This will include past psychiatric and past medical (diseases other than psychiatric disorders) history. The doctor should collect information regarding past similar psychiatric disorders, past other kinds of psychiatric disorders, the symptoms and duration of the disorders, the treatment received including pharmacological, physical and psychosocial methods with necessary details, investigations done, whether hospitalized or not, treatment adherence, response to treatment, adverse effects, outcome, probable clinical diagnosis, untreated episodes, episodes managed with alternate medicines (non-modern medical practice), deliberate self-harm, substance use, dangerous behaviour, and legal involvement.

Essential clinical data regarding all significant past medical, surgical, gynaecological, and other non-psychiatric disorders are gathered in past medical history. It is wise to ask specifically for seizure disorder, traumatic brain injury, Parkinson's disease, thyroid diseases, diabetes mellitus, asthma, COPD, cardiac diseases and tuberculosis. The doctor always gets essential details about the treatment received by the patient and the outcome while on treatment. He enquires specifically about neurosurgery, and other surgeries done with details including general anaesthesia. The doctor should remember to ask for allergies and allergic diseases if any.

FAMILY HISTORY:

The family history includes a family tree, essential details regarding members of the family, the general functioning of the family, and psychiatric and other medical disorders in the family. It is advisable to have a family tree back to the grandparents. Gather essential data regarding members in the family that include name, age, occupation, health status, personality traits, deaths if any, and causes of death. Data regarding the general functioning of the family should include the type of family, social position, social class, education, occupation, religion, culture, income, cohesion, interpersonal relationships, and family atmosphere. Essential data regarding relevant psychiatric and other medical disorders in at least first and second-degree relatives is an important part of the family history,

particularly for diagnosis and management. This part of the family history should have necessary data regarding psychiatric disorders and also about deliberate self-harm, suicide, substance use, recidivism, violence, mental retardation, eccentric persons and physical, psychological or sexual abuse. The doctor should gather essential data regarding other relevant medical disorders like seizure disorders, Parkinson's disease, Alzheimer's disease, cerebrovascular diseases, diabetes mellitus, thyroid diseases, hypertension, ischemic heart diseases, chronic obstructive pulmonary diseases, obesity, neoplasms, and others. Many of the patients and informants are reluctant to disclose their family details. Hence, the doctor must make special efforts to get the essential data perhaps in certain contexts. He may enquire specifically about each one of the relevant disorders and diseases. The general enquiry whether any members in the family have or have had any major mental or medical diseases may not be sufficient on most occasions. Quite often the doctor may have to ask specifically about disorders and diseases to elicit reliable data. Whenever possible get a neutral informant to gather family history.

PERSONAL HISTORY:

The personal history includes birth history, early development, persistent early behaviour or early character traits, health during childhood, schooling and education, occupation, menstrual history, sexual history, and marital history. Essentially the personal history consists of both the developmental and the social history of the patient.

Birth history should provide data regarding at least the date and place of birth, nature of delivery, full term, preterm or post-term birth, anoxia if any at birth, antenatal, natal and postnatal complications, feeding, growth and immunization. In **early developmental history,** the doctor elicits data regarding developmental milestones (motor, language and social) and adaptive behaviour. If any delay or failure is reported, he should get appropriate details about the same. **Persistent early behaviour or early character traits** were popularly known as neurotic traits in childhood in the past. The term neurotic is avoided due to theoretical implications and inherent confusion. All of them need not necessarily be character traits. This part of developmental history will elicit data regarding night terrors, nightmares, sleepwalking, bed wetting, nail-biting, thumb sucking, faddism for food, stammering, fear states, temper tantrums, and other persistent behaviour. **Schooling and education history** will provide data regarding the age of beginning and finishing schooling, types of schools attended, levels of education attained, academic achievements, special difficulties,

disabilities and abilities, relationships with peers, teachers and authorities, extracurricular abilities and interests and problems with discipline. **Occupational history** provides data regarding jobs and work. The doctor elicits data regarding age at beginning work, types and nature of works undertaken, wages or salary, reasons for change of jobs if any, attainments and difficulties at work, degree of job satisfaction with reasons for the same, coping with work, boredom, strict requirements and demands, economic status, ambitions, hazards if any, promotions, work records, interpersonal relationships at work, retirement and coping with retired state. **Menstrual history** will provide information regarding age at menarche and response to the experience, information and attitude towards menstrual cycles, regularity, quantity, duration, pain and other details about the cycles, associated behavioural and experiential changes, last menstrual cycle and menopause and related alterations in behaviour. **Sexual history** will gather data regarding the sexual knowledge of the patient, his attitude to sexual behaviour and experience, sexual adjustments, preferences and practices, fantasies and masturbation, premarital, marital and extramarital sexual relations, homosexual inclinations and experiences, guilt related to sexual behaviour and sexual assaults if any. **Marital history** provides information regarding the date of marriage, the type of marriage (love marriage/arranged marriage), nature and duration of contact before marriage, age, education, occupation, health, substance use, legal issues and personality traits of the spouse, sexual life and satisfaction, sexual dysfunctions, use of contraceptives, miscarriages and abortions, data regarding children and interpersonal relationships with spouse and children.

PREMORBID PERSONALITY:

History regarding the premorbid personality of the patient and in instances when it is not available inter-morbid personality is an essential aspect of psychiatric clinical history. Whenever possible the doctor should get a thumbnail sketch about premorbid remarkable character traits from the patient himself. The doctor should also collect independent neutral data from appropriate informants if available. Always an attempt should be made to get a complete picture of his premorbid personality if possible. Very often it is a difficult and time-consuming task. There are no universal recommendations for collecting data regarding premorbid personality. However, the following guidelines given in clinical textbooks may help the doctor to be comprehensive in gathering the essential data. The data could be collected under the following headlines: social relations, intellectual activities and interests, mood states, character and habits (Meyer-Gross et al. 1969, Gelder et al. 1996).

In premorbid **social relations**, data regarding his interpersonal relationships with family, friends, colleagues, in groups, in clubs, and in societies are gathered. Specifically, the data about his ability to sustain relationships, trust others, tolerate criticisms, and take responsibility for maintaining relationships and collective decisions are obtained. Finally, information about the nature of the relationships that particularly include the degree of attachments, dependence and interdependence in relationships, preference to be a leader or a follower, ability to be an organizer, inclinations to be aggressive, dominant, submissive or adjustable, and tendency to be an extrovert, introvert, ambivert or omnivert are gathered. In premorbid **mood states** the doctor gathers information regarding the predominant mood states, the ability to express and control the mood, the stability of the mood, and swings in mood states. In addition, the doctor collects data about whether he is mostly cheerful, despondent, worrying, anxious, optimistic, pessimistic, realistic, satisfied, dissatisfied, confident, overconfident, self-depreciative or demonstrative. Under **premorbid character** data regarding attitude to work and responsibility, practical attitude to self, others, relationships, health and life, and moral, religious, and social standards are collected by the doctor. The doctor should also gather information regarding coping strategies in stressful contexts, the ability for impulse control, role performance, energy levels, and the fantasy life of the patient. Under **premorbid habits,** the doctor gets information regarding the biological (sleep pattern, bowel habits) and social (personal cleanliness, smoking, pattern of use of substances) habits of the patient. The data will indicate whether the premorbid habits are clean, unique, peculiar, or inappropriate.

The following enquiry is an example of eliciting premorbid personality history from a patient. “I am now going to ask you a few questions about how you were before the beginning of the disorder/problems/symptoms you have now. How would you describe yourself as a person? What were your remarkable strengths and weaknesses? How did you get on with others? Who were your preferred company? Were you a religious person? What were your unique interests? Could you describe your moods and emotions? How did you react to stress? How did you manage your impulses? What were your common dreams, ambitions, and fantasies?” The doctor should make sure that he elicits the premorbid history and not the current history (altered personality traits after onset of the disorder), or a combination of both. Similar enquiries could be made with the reliable neutral informant about the premorbid personality of the patient.