DATA BASE

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INTRODUCTION

The data base in psychiatry is similar in many respects to the data base in general medicine. Like the latter, it contains a narrative description of the nature and development of the patient's illness, an assessment of the patient's current mental and physical status, a relevant past history, a family history, a review of systems, and results of appropriate laboratory evaluations. However, there are parts of the psychiatric data base which receive special emphasis, i.e., the mental status examination. Other parts are not always found in the general medical data base, i.e., the developmental history.

The **mental status exam** documents the patient's behavior, emotions and thoughts at the time of the examination. By observing the patient and by eliciting information through appropriate questions, the examiner is able to develop a descriptive picture of the psychiatric patient. The data in the mental status examination is helpful in establishing an appropriate differential diagnosis. Of equal importance, however, the mental status examination provides a record of behavior which can be used as a baseline against which response to treatment or progression of disease can be measured.

The **developmental history** helps the physician understand the patient's personality organization and the dynamics underlying both interpersonal and intrapsychic events. Obtaining a thorough developmental history is an important part of the ongoing psychotherapeutic process.

The ability to take an accurate, concise history and to perform a precise examination is the basis of good medical practice. This is particularly so in psychiatry, where numerous influences are at work on the patient. The psychiatric interview is the instrument used to appraise these influences. Sharpening your psychiatric interview skills is one of the main objectives of ICM interviewing and your psychiatry clerkship.

Various parts of the psychiatric interview will be described below. In general, there are three major aims:

1. To elicit information. In many cases accuracy and veracity will be limited by the patient's psychopathology. Another informant(s) should also be interviewed whenever possible. In moving from topic to topic, you should exercise tact and be prepared to hear the patient out, but still maintain overall control so that the items that need to be covered are addressed in the available time.

2. To observe the patient's general demeanor and attitudes. Firing questions from a checklist at the patient must be avoided or this objective will be missed. The interaction between you and the patient, including the rapport that builds up between you, is a vital clue in assessing his/her interactions with others and understanding the patient as a person. To do this, you will have to learn to be both responsive to and watchful of what goes on between you.

3. To begin the therapeutic alliance. If the patient is harried and does not form the impression that you will make an effort to see things from his/her point of view (without necessarily agreeing with them all), and to help him/her meet various needs, the prognosis for the outcome of treatment will be poor. The converse also applies.

PSYCHIATRIC DATA BASE

1. IDENTIFYING DATA - age, sex, marital status, occupation.

The patient is a 42-year old married woman with two children who works as a chemical engineer.

2. CHIEF COMPLAINT - Statement of the reason for hospitalization from the patient's point of view and from pertinent others' point of view.

The patient states that 'there is no use living any longer.' Her physician referred her to the hospital because he feared she would attempt suicide.

3. HISTORY OF PRESENT ILLNESS - Narrative summary of present problems. Include prior episodes of similar illness and response to treatment. Include pertinent negatives. Note from whom the history is obtained.

(History is obtained from the patient, her husband and her physician).
The patient was well until three months prior to admission, at which time she began awakening in the early hours of the morning. She would pace around her home, unable to return to sleep, and would complain to her husband about financial obligations and vague fears for the safety of her children. She soon became obsessed with completely unrealistic concerns about bankruptcy and blamed herself for having raised her children unskillfully, despite their obvious satisfactory adjustment. Six weeks prior to admission, she 'lost interest in food', discontinued sexual relations, and over the subsequent six weeks lost nine pounds. She had great difficulty leaving the house to go to work, and became less productive on the job, although by late afternoon she functioned more normally. Two weeks prior to admission, she refused to go to work, claiming her 'intestines were plugged, probably by cancer', and began to spend most of her time in bed. She was persuaded to visit a family physician one week prior to admission who elicited suicidal ideation, diagnosed depression, and prescribed imipramine 25 mg b.i.d.

Despite the medication, the patient became more seclusive and rarely spoke except to bemoan her fate and urge people to leave her alone because things were 'hopeless'. On the evening prior to admission, she ingested all her remaining imipramine tablets (10 tablets, 25 mg each), saying 'I just want to go to sleep and not get up.' Her husband and physician urged the patient to seek hospitalization, and she grudgingly agreed.

Past history is significant for a depressive episode following the birth of her second daughter at age 29. One week postpartum, she became agitated, tearful, and felt unable to care for her new infant. She spent the next three weeks at her stepmother's home, giving the bulk of child care duties to her stepmother. She did not seek psychiatric help and slowly improved spontaneously.

There is no past history of clear-cut manic or hypomanic episodes, alcohol or drug abuse, or suicide attempts.

4. PAST PSYCHIATRIC HISTORY - Specify dates of treatment, type of facility, specific treatment modalities (e.g., medication dosage and duration).

There is no past history of inpatient or outpatient psychiatric treatment.

5. PAST MEDICAL HISTORY (per Dept. of Medicine)
6. MEDICATIONS (per Dept. of Medicine) - All medications patient is currently taking; be sure to specify drug name, dose, route of administration, and frequency of dosing.

Imipramine 25 mg p.o. bid

7. ALLERGIES (per Dept. of Medicine)

8. DRUGS/ALCOHOL - History of use of alcohol and non-prescription drugs and abuse of prescription medications. Specify both past and current drug/alcohol use: drug names, amount and duration of use, use of IV drugs, whether needles were shared, history of DWI's, DT's, blackouts, withdrawal symptoms, periods of abstinence/sobriety, and drug and alcohol treatment.

Patient states she is social drinker (3 drinks/month). She denies any past or current alcohol or drug abuse.

8. FAMILY MEDICAL HISTORY (per Dept. of Medicine)

9. FAMILY PSYCHIATRIC HISTORY - Emphasis on first-degree relatives. Ask about: mental retardation, alcoholism, drug abuse, depression, schizophrenia, "nervous breakdown", psychiatric treatment, antisocial behavior, suicide.

The patient's mother had several episodes during which she was 'depressed' for several months but never received psychiatric treatment. The patient's maternal grandfather abused alcohol.

✓ 10. DEVELOPMENTAL HISTORY - Birth and early development, childhood adjustment at home and school, sexual development, adolescence, high school and advanced education, career, military service, legal entanglements, marriage(s), etc. Discuss patient's relationship with parents and siblings while growing up.

The patient's birth and early developmental milestones were normal. She performed well scholastically in elementary and junior high school, but was shy in interpersonal relationships with peers and often worried excessively that she would fail in her studies. She recalls 'playing sick' during her early school years so as to be able to stay home with her mother rather than attend class. The patient was an only child whose mother died of breast cancer when the patient was 10 years old. She was told by relatives that for two months after her mother's death, she was withdrawn and took little interest in school or family. Her father remarried two years afterwards, but the patient felt that her new stepmother was much more nurturant toward her own two biological children than to the patient. Her menarche was at age 14. She did not become socially active with members of the opposite sex until her junior year in high school. Her dating pattern was such that she always had one relationship. Each termination of these early relationships was inevitably stormy and always produced an acute sense of loss and emptiness which lasted for several months. The patient was a hardworking, precise, and industrious student in high school, and in college earned excellent grades. She received a degree in engineering and obtained much satisfaction from having mastered a field in which few persons felt that she would succeed. She married at age 22 'because I wanted children.' Her husband was described as a

reliable but undemonstrative man who occasionally expressed resentment at the demands his wife's career placed on his own life. Although the patient felt that she frequently disagreed with her husband, the couple rarely argued.

11. SOCIAL HISTORY - Describe patient's present family situation, residential setting, occupation, financial status.

The patient lives in a single family home with her husband and 13-year old daughter. An 18-year old daughter is away at college. The patient has worked for a large engineering corporation for the past fifteen years and has been in an administrative position for the past seven years. Family income is upper middle class. Both the patient and her husband are college graduates.

12. LEGAL/VIOLENCE HISTORY - History of arrests, convictions, prison time, assault charges, fights, domestic violence.

There is no history of legal problems or violence.

13. REVIEW OF SYSTEMS (per Dept. of Medicine)

14. PHYSICAL EXAMINATION (per Dept. of Medicine)

15. MENTAL STATUS EXAMINATION

A. APPEARANCE. Describe how the patient looks. General appearance includes: apparent age, body type, dress, posture and personal hygiene.

B. BEHAVIOR. Describe how the patient acts during the interview. Observations of motor behavior should include comments on: gait, abnormal movements, rhythm and coordination, speed and frequency of gestures, psychomotor agitation or retardation. Note patient's degree of cooperation.

agitation - excessive motor activity usually not goal-directed (e.g., inability to sit still, fidgeting, pacing, or wringing of hands, foot tapping). Agitation refers only to the motor behavior and not the psychological state.

hyperactivity - increased frequency of gross activity which is usually goal-directed (e.g., talking to several people one after the other; going to one place and then another in quick succession).

catatonic state - a state most typically characterized by muscular immobility. At least 25% of catatonics are suffering from a mood disorder. Mutism is not synonymous with catatonia. Some catatonics have waxy flexibiity in which the patient assumes or can be placed in odd postures which are maintained for long periods of time.

facial expressions - flat expressionless face is most characteristic of schizophrenia. Grimacing and other fixed facial postures can also occur.

stereotypy - repeated non goal-directed motor behavior (e.g., the patient knocks his/her forehead repeatedly with knuckles) or speech.

posturing - assuming odd body positions.

C. SPEECH. Volume, rate, pressure, spontaneity, coherence, latency of speech. The rate of speech can be speeded, slowed, halting, or dysrhythmic (often seen in Huntington's chorea and multiple sclerosis). The rate of thoughts can only be reported by the patient but can be inferred from the rate of speech.

Speech latency - delay in responding and initiating speech. Increased speech latency is characteristic of depression. Slow and/or hesitant speech is characteristic of depression, altered states of consciousness, and certain organic brain diseases where the ability to select and/or express the proper words is defective (aphasia).

Pressured speech - refers to the drive to talk. Rapid pressured speech is a cardinal sign of mania. Slightly pressured speech can occur with anxiety.

D. MOOD AND AFFECT - Mood is the patient's subjective emotional state: the type of emotions such as sadness, anxiety, resentment, happiness should be recorded (in the patient's own words if possible, e.g., "I feel depressed."). Affect is the observable (by the interviewer) evidence of the patient's emotional state (how the patient "looks" emotionally). Affect has range, intensity or amplitude, stability, and appropriateness to mood.

range - Variability of emotion over a period of time. Range of affect tends to be restricted in depression and expanded in mania.

intensity - Intensity of affect refers to the amplitude of emotions. It does not refer to variability. The psychomotor epileptic can shout and rage with great force, never varying his intensity, until overcome with exhaustion. His range is totally restricted but his affective amplitude is intense.

stability - This refers to the rapidity of change in mood and affective intensity. Normal changes occur relatively slowly during the course of the day. Rapid shifts during the interview are pathological. Lability of affect (instability) is characteristic of mania and various organic brain diseases (e.g., pseudobulbar palsy).

mood or affect appropriateness - Inappropriateness of mood (feeling elated in a sad situation), while significant, is not diagnostic because it is present in many serious psychiatric illnesses. Similarly, inappropriate affect such as smiling when feeling sad can occur in a wide range of diagnoses.

relatedness - Refers to the ability of the patient to express warmth and to interact emotionally with the interviewer. Schizophrenics often are unable to respond in this manner and often appear cold and unfeeling. You might feel you are addresssing a computerized voice.

E. THOUGHT PROCESSES AND CONTENT

1) THOUGHT PROCESSES: associations, organization, and relevancy of thought. Thought processes can be examined in terms of coherence, tightness of associational linkage and idiosyncracy of word usage.

word usage - neologisms and word approximations. This is one type of "formal" thought disorder (abnormality of the structure or "form" of thought) and is frequently observed in organic brain disease and schizophrenia.

Examples:

'I need a flamis to binkle my bed.' (schizophrenia)

'I know the time by the thing that goes around.' (Alzheimer's disease)

loosening of associations - loosening of associations refers to the apparent disruption of meaningful connections between words or phrases. Loosening of associations is not pathognomic of schizophrenia. Mild loosening is most frequent when anxiety is severe. More severe loosening occurs in psychotic disorders such as mania or schizophrenia. Two important questions to ask are: how loose are the associations and what is the form of looseness, the nature of the linkage?

a. Disturbed thought processes with normal associations:

circumstantial - The patient's thought process is goal-directed but over-inclusive of unnecessary and irrelevant detail. This is the typical speech of organic brain syndromes (e.g., stroke, head trauma). It is also frequently seen in nondemented geriatric patients and other nonpatient populations.

Example: *'I'm a secretary. I've been working all my life. It's been hard, but I've always worked. Now take this present job. I don't like the boss. He's the type who thinks they own the world. I'm not going to clean up for everyone. Not me. No sirree.'*

tangential thoughts - Although consecutive thoughts are associated, the thought process is not directed in a straight line toward a goal. This is often seen in mania.

Example:
'What kind of work do you do?'
'I'm a bricklayer. Been doing it for years. Bricks use a lot of straw. On a farm you use the straw for bedding.'

perseveration or *verbigeration* - There is a persistent tendency to repeat the same verbal or motor response.

Example:
'My house burned down, burned down, burned down, burned down.'

b. Disturbed thought processes - with loosening of associations:

mild loosening - Simple loosening refers to loosening of associations between paragraphs.

flight of ideas - Continuous speech with rapid shifting from one idea to another. Flight of ideas is typical of mania.

Example:
'It is a beautiful day....the sky is blue...I have a nail in my shoe...I'm hungry...I have to get a new coat.'

thought blocking - Interruption of a train of speech before a thought has been completed. After a period of silence which may last from seconds to minutes, the person indicates that s/he cannot recall what s/he had been saying.
word salad - Word salad refers to loosening between words so that consecutive words seem unrelated in meaning.

Example:
'I or what what the sky he me she she she cold it.'

Clanging - Associations are made by the sound (rhyming, punning) rather than the meaning of words or phrases. Typically observed in manic states.

Example:
'Clanging, banging, hanging, dangling.'

2) THOUGHT CONTENT: Unusual thoughts, preoccupations, and experiences (delusions, hallucinations, phobias, obsessions, compulsions, hypochondriasis, fears, suicidal ideation, etc.).

delusion - A false belief firmly held in spite of what almost everyone else believes and in spite of what constitutes incontrovertible and obvious proof or evidence to the contrary. Further, the belief is not an ordinarily accepted by other members of the person's culture or subculture (i.e., it is not a commonly believed superstition). The boundaries of the concept of delusion are unclear when the belief involves an extreme value judgment. For example, if an individual claims he/she is a terrible person and has disappointed his/her family, this is generally not regarded as a delusion even if an objective assessment of the situation would lead observers to think otherwise. If the individual claims that he/she is the worst sinner in the world, however, this would generally be considered a delusional conviction. Similarly, a person judged by most people to be moderately underweight who asserts he/she is fat would not be regarded as delusional; but one with Anorexia Nervosa who at the point of extreme emaciation insisted he/she was fat could rightly be considered delusional.

A delusion should be distinguished from a ***hallucination***, which is a false sensory perception (although a hallucination may give rise to the delusion that the perception is true). A delusion is also to be distinguished from an idiosyncratic, fleeting, false belief that is abandoned when evidence to the contrary is available. The term delusion is not usually applied to a false belief held for a short time that is attributable to a brief, intense emotional experience, e.g., a panic attack, severe phobia, or obsessive-compulsive symptomatology.

Delusions are described according to their content (e.g., persecutory, grandiose, jealousy, nihilistic, religious, sexual, somatic, poverty). Several types of delusions represent common themes and thinking processes in psychotic states. These include:

delusion of being controlled - A delusion in which the person experiences his/her feelings, impulses, thoughts or actions as not his/her own, as being imposed on him/her by some external force. This does not include the mere conviction that s/he is acting is the victim of fate, or is not sufficiently assertive, or that someone is trying to control him/her.

synonyms: delusion of being influenced, delusion of passivity.

delusion (ideas) of reference - A delusion whose essential theme is that events, objects, or other people in the person's immediate environment have a particular and unusual meaning specifically for him/her. If the delusion of reference involves a persecutory theme, then a delusion of persecution is present as well.

> Examples: *A man believed that when a doorman tipped his hat, it was a signal that the CIA was following him. A 38-year old women was convinced that programs on the radio were directed especially to her. When recipes were broadcast, it was to tell her to that her food was being poisoned.*

thought broadcasting - The patient's experience is that as his/her thoughts occur, they are escaping from his/her head aloud into the external world. This experience is not a hallucination but is often associated with a delusional notion involving telepathy, electronic surveillance, etc.

> Example: *A young man came to a psychiatry emergency clinic on his seventeenth birthday to see what could be done about 'the machines' being used to 'broadcast' his thoughts. In an interview with him and his parents, the patient felt foolish and patronized when asked to speak as it was clear to him that we already know what he was thinking. He frequently responded with 'Come on ... you know', etc.*
>
> Questions that can quickly elicit information on these delusions include: *'Do you feel that your thoughts or actions are being controlled?', 'Do you feel that your thoughts are escaping your head?'*, and *'Do you feel you are getting special messages from the TV, radio, or other things?'*.

Hallucinations - A sensory perception without external stimulation of the relevant sensory organ. Except for hypnogogic and hypnopompic hallucinations (see below), the term usually implies a pathological state. A hallucination has the immediate sense of reality of a true perception, although in some instances the source of the hallucinations may be perceived within the body (e.g., an auditory hallucination may be experiences as coming from within the head rather than through the ears). Some investigators limit the concept of true hallucinations to sensations whose source is perceived as being external to the body, but the clinical significance of this distinction has yet to be demonstrated.

There may or may not be a delusional interpretation of the hallucinatory experience. For example, one person with auditory hallucinations may recognize that he is having a false sensory experience whereas another may be convinced that the source of the sensory experience has an independent physical reality.

Exclusions: the term is not ordinarily applied to the false perceptions that occur during dreaming. Similarly, hallucinations occurring in the course of a religious experience may have no pathological significance.
Hallucinations should be distinguished from illusions, in which an external stimulus is misperceived or misinterpreted. Transient hallucinatory experiences are common in people without a mental disorder.

auditory hallucination - a hallucination of sound, most commonly of voices, but sometimes of clicks, rushing noises, music, etc. Clear voices speaking in sentences are generally considered pathologically, while single words (particularly your own name) or muffled sounds have less significance.

gustatory hallucination - a hallucination of taste, unpleasant tastes being most common.

hypnogogic hallucination - a hallucination occurring while falling asleep. Ordinarily not considered pathological. This and hypnopompic hallucinations occur in 10-15% of the normal population, usually in a REM state with motor paralysis.

hypnopompic hallucination - a hallucination occurring while awakening from sleep. Ordinarily not considered pathological.

olfactory hallucination - a hallucination involving smell.

Exclusion: Some individuals are convinced they have a body odor they themselves cannot smell; this symptom is a delusion, not an olfactory hallucination.

tactile, or haptic, hallucination - a hallucination involving the sense of touch, often of something on or under the skin. Almost invariably, the symptom is associated with a delusional interpretation of the sensation.

> Examples: *A man said he could feel the Devil putting pins into his flesh. Another claimed he could feel himself being anally penetrated. Still another complained of experiencing pains throughout his body which he attributed to the Devil, but there was no evidence of any physical illness.*

A particular haptic hallucination is *formication*, which is the sensation of something creeping or crawling on or under the skin. Often there is a delusional interpretation of the sensation; it may be attributed to insects or worms. Formication may be a sign of organic brain syndromes such as alcohol withdrawal or drug-induced psychosis.

Tactile hallucinations of pain are distinguished from psychogenic pain by the absence of a delusional interpretation in the latter.

visual hallucination - hallucination of sight, which may consist of formed images, such as of people, or of unformed images, such as flashes of light.
Exclusions: visual hallucinations are to be distinguished from illusions, which are misperceptions of real external stimuli.

F. INTELLECTUAL FUNCTION

A reasonable screen for cognitive function includes orientation (person, place, time), past presidents (the last four), serial 7's, recall of 3 objects at 2 minutes, and abstraction of 2 proverbs. However, this is not adequate for the patient in whom you suspect there may be cognitive impairment or in whom you wish to follow cognitive function that may be changing over time. A more standard, objective, and commonly used brief (5 minutes) cognitive screening exam is the Mini-Mental State Exam (Folstein and Folstein), a 30-point screening exam of cognitive function that assesses orientation, memory, calculation, language, and constructional praxis. **The Mini-Mental State Exam (MMSE), which assesses only cognitive function, is to be distinguished from the *MENTAL STATUS EXAMINATION*.**

Before administering the Mini-Mental State Exam, the patient's level of consciousness and attention span and level of education should be noted.

MINI-MENTAL STATE EXAM (Folstein & Folstein):

ORIENTATION

1. What is the (year) (season) (date) (day) (month)
(maximum score: 5)
2. Where are we (state) (county) (city) (hospital) (floor)
(maximum score: 5)

REGISTRATION

Name 3 objects (ball, flag, tree): One second to say each. Then ask the patient for all 3 after you have said them. Give one point for each correct answer (maximum score: 3). Then, repeat them until he/she learns all 3.

ATTENTION AND CALCULATION

Serial 7's (Take the number 100 and subtract 7. Now keep subtracting 7) or spell "world" backwards. One point for each correct answer (maximum score: 5).

RECALL

Ask for the 3 objects repeated above. Give one point for each correct answer. (maximum score: 3).

LANGUAGE

1) Name a pencil and watch (2 points).
2) Repeat the following: "No ifs, ands, or buts." (1 point).
3) Follow a three-stage command: "Take this paper in your right hand, fold it in half, and put it on the floor." (3 points).
4) Read and obey the following: CLOSE YOUR EYES (1 point)
5) Write a sentence (1 point).

CONSTRUCTIONAL PRAXIS

Copy design (intersecting pentagons) (1 point).

The total score for all answers correct is 30. Normal young persons with at least a high school education score at least 28 and normal older persons with at least a high school education rarely score below 26. Normal persons with limited educational backgrounds may score below 26.

Interpretation of responses to orientation questions:
Responses to questions of orientation are suggestive of diagnosis. Manic and schizophrenic patients are usually oriented. A response within a day or two fo the actual

date is usually accepted as normal; strange responses (e.g., "this is another planet", "we're in the future") suggest psychosis or hysteria; precise but incorrect dates corresponding to the onset of illness suggest anterograde amnesia; vague, incorrect but mundane responses (e.g., "I'm home") suggest organic brain syndrome.

Miscellaneous comments:
The ability to concentrate is often impaired by a patient's anxiety or fatigue. An altered mood (depression or elation) or intrusive thoughts or perceptions can also interfere with concentration.

Intellectual impairment is frequently observed in psychiatric patients. Schizophrenia should be considered if the patient has clear consciousness without evidence of organic brain disease.

> *Confabulated memory* can be evaluated by suggesting false events to the patient who may agree and elaborate. Confabulation is most frequently observed in Korsakoff's encephalopathy but "fantastic" confabulations can occur in mania
>
> *Amnesia* is the inability to recall past events. Retrograde amnesia refers to the inability to recall events prior to a usually traumatic event (psychological or physical). Anterograde amnesia refers to the inability to recall events following the traumatic event. It usually implies an altered sensorium and frequently acute brain dysfunction. The longer the period of anterograde amnesia, the more severe the dysfunction.

ABSTRACTION - The Mini-Mental State Exam does not test abstraction ability. A fairly reliable and valid test would be:

1. Similarities:
   Q. What is the similarity between an orange and an apple?
   A. They are both fruits.

   Q. What is the similarity between an airplane and a bicycle?
   A. They are both means of transportation.

   Q. What is the similarity between paint and concrete?
   A. They both must dry and harden to function properly.

Proper answers to the first two questions suggest normal intelligence. A proper answer to all three questions suggests above average intelligence.

2. Interpretation of two proverbs: Failure to abstract these is mainly a function of IQ and cultural and school experience. Schizophrenics who had demonstrated above average IQ when younger may lose the ability to abstract and may give very concrete answers. Bizarre, idiosyncratic answers are more pathognomic of psychosis.

> Examples:
> *People who live in glass houses shouldn't throw stones = 'Don't criticize your neighbors because you're worse than they are.'*
> *A rolling stone gathers no moss = 'Nothing works out for people who stay in one place.'*

G. JUDGMENT AND INSIGHT - Decisions concerning the patient's life situations and reality problems offer the best chance to evaluate judgment. Does the patient realize the nature of his/her illness?

MENTAL STATUS EXAM ON CASE PRESENTED ABOVE:

appearance - *The patient was a neatly dressed middle-aged woman.*

behavior - *The patient sat quietly in a chair, occasionally wringing her hands. She resisted eye contact with the examiner, directing her vision toward the floor. Cooperation was initially poor, although the patient responded to questions if firmly directed. There was a paucity of motor movement.*

speech - *Speech was slowly paced and reduced in volume. Speech was coherent but there was a long latency of response and little spontaneity.*

mood and affect - *The patient stated she felt hopeless and 'empty inside'. She appeared very depressed and occasionally irritated, although she did not directly express anger. Affect was appropriate to thought content.*

thought processes - *Thoughts were coherent, normally associated and relevant. 'I just don't feel that answering all these questions will do any good. Nobody can help me now.'*

thought content - *The patient repeatedly stated that her bowels were blocked and that there was a cancer growing in her abdomen which the doctors refused to tell her about. She feared that she had ruined her family's future because of a flirtation she had with a man at work, and was concerned that her daughter's reputations were ruined. She denied hallucinations or persecutory ideation. She claimed she wished she could die, but did not 'have the courage' to kill herself.*

cognitive - *The patient was alert, but appeared preoccupied and sometimes lost the thread of conversation. Education level - college graduate. Mini-Mental State Exam score 30/30. Fund of knowledge - 4/4 past presidents.*

judgment and insight - *The patient does not realize she is depressed and is convinced that her perception of reality is accurate.*

16. LABORATORY - all psychiatric inpatients deserve a routine screening for medical illnesses which may present with psychiatric symptoms. Helpful tests include:

Routine

serum electrolytes (sodium, potassium, bicarbonate, chloride, calcium, phosphate)
serum BUN/creatine (renal failure)
serum bilirubin, SGOT, SGPT, LDH (hepatic dysfunction)
serum glucose (hypoglycemia)
serum albumin, total protein (nutritional status)

complete blood count
urinalysis
urine toxicology screen (intoxication)
urine pregnancy test (women of childbearing potential)

Optional (per differential diagnosis)

thyroid function tests -T4, T3U, TSH (hypo-, hyperthyroidism)
serum VDRL or RPR (syphilis)
serum B12 (pernicious anemia)
CT or MRI brain scan (intracranial mass lesion, cortical atrophy)
EEG (seizure disorder)
chest x-ray (congestive heart failure, tumor)
aminolevulinic acid & porphobilinogen (acute intermittent porphyria)
serum ceruloplasmin (Wilson's disease)
serum ANA (lupus erythematosus, other autoimmune vasculitides)
lumbar puncture (CSF protein, glucose, cells, gram stain, cultures)

17. DIAGNOSIS OR IMPRESSION - DSM-III-R CLASSIFICATION

AXIS I. Clinical syndromes and conditions attributable to a psychiatric disorder.

AXIS II. Developmental disorders (includes mental retardation, specific developmental disorders, and pervasive developmental disorders) and personality disorders.

AXIS III. Any physical disorder or condition that may be present in addition to a pyschiatric disorder. The physical disorder may or may not be related to the psychiatric diagnosis.

AXIS IV. 6-point rating scale for psychosocial stressors that contribute significantly to the current psychiatric disorder(1=none...6=catastrophic) .

AXIS V. 90-point global assessment scale of highest level of functioning during the past year (composite of social relations, occupational functioning, and psychological functioning; 90=absent or minimal symptoms ... 10=persistent danger of severely hurting self or others, etc.).