An Introduction to the practice of psychiatry in Africa

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Dedication

This book is dedicated to my wife Christine and children: Brian, William and Susan; thank you for being such great company.

Preface

This book arose out of my experiences practicing and teaching psychiatry in Kenya and Botswana. The bulk of first contact psychiatric care is given by general medical officers and nurses, yet there are very few locally relevant books and reference materials aimed at these frontline practitioners. Although this book is aimed at them, it is also useful for medical students, psychiatric nurses in training and other doctors who at one time or another have to deal with mental illness, meaning virtually every doctor.

The book makes no pretense at being an exhaustive textbook of psychiatry and mostly covers the minimum knowledge one needs to know about those conditions one is likely to come across in primary care. It leaves out most of the theory.

At the end of some chapters is a section titled "IN PRACTICE". This section contains observations or advice derived from my years of practicing psychiatry.

Where mention is made of less-than-"best practice" practices one may encounter in the hospitals or clinics, the reference is made in good faith, to serve as a learning experience.

I would like to thank the staff of all the psychiatric units and departments I have worked in; both in Kenya and Botswana who made me realize the need for such a book.

I would also like to thank all my students at the University of Botswana; some of whom have kept asking why all the books they use in Psychiatry make no reference to relevant local examples.

While many people read portions of the manuscript as it was under preparation and made useful comments, I acknowledge that all mistakes of fact are solely mine. I therefore welcome suggestions and corrections for future improvement.

Special mention goes to my colleagues Dr. James Otieno Ayugi and Dr.Margo Pumar for their comments and encouragement, to Professor Michael Blank of the University of Pennsylvania for his comments on the chapter on psychological methods of treatment.

I would also like to thank Undimilile Pilato of Nyangabgwe Hospital, Botswana and Olga Naane of the University of Botswana for their secretarial input.

My thanks also go to others who made their input but who are not mentioned by name.

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Chapter 1

Introduction to psychiatry

What is psychiatry?

Psychiatry is the study, diagnosis, treatment and prevention of mental disorders. The term psychiatry was coined by Johann Christian Reil in I808 derived from the Greek words "Psyche" for soul or mind and "Iatros" for treatment or physician. So one may say psychiatrists are physicians of the mind. Mental disorders have been with mankind since antiquity and there are references to mental illness dating back to biblical times. Treatment in psychiatry has evolved greatly and now is usually a multidisciplinary effort involving other disciplines like nursing, psychology, social work and occupational therapy.

Confusion sometimes exists especially in lay persons about the difference between a psychiatrist and a psychologist. A psychiatrist is a medical doctor who specializes in the treatment of mental disorders. This means for one to become a psychiatrist they have to train as a medical doctor first. While a psychologist also treats people with emotional and mental disorders psychologists do not necessarily have to be medical doctors first. In most countries of the world psychologists do not prescribe medication.

Psychiatry in Africa

The history of psychiatry across Africa has generally followed a similar pattern in almost all countries; moving from locking up of "lunatics" as the mentally ill were then called with a view to containing them rather than treatment, to setting up of psychiatric hospitals. More recently in line with international trends more emphasis is being placed on community based mental health care in some countries.

Despite the fact that mental and neuropsychiatric disorders contribute to 14% of the global burden of disease; in almost all African countries mental health is not given priority, with most countries allocating less than 1% of the health budget to mental health.

The bulk of psychiatric care in Africa is provided by psychiatric nurses. Africa has very few psychiatrists with less than 1 psychiatrist catering for 100,000 people. The countries

with the highest concentration of psychiatrists are Egypt, South Africa, Nigeria and Kenya in that order. Where psychiatrists are available the majority are either in private practice or serving in the psychiatric hospitals in urban areas.

Efforts have been made to integrate mental health into primary health care but there are still few community based structures to support out of hospital psychiatric care but most of psychiatric services are hospital based.

Diagnostic and classification systems in psychiatry

The two major classification systems in Psychiatry are: the International **Classification of diseases, Chapter 10 (ICD 10)** by the World Health Organization and the **Diagnostic and Statistical Manual (DSM)** by the American Psychiatric Association.

International classification of diseases (ICD 10)

The ICD 10 is widely used worldwide by WHO member countries for statistical reporting on diseases. It is being revised and ICD -11 is due for release in 2017. In psychiatry the ICD 10 for Mental and Behavioral disorders Clinical descriptions and Diagnostic guidelines (the blue book) is used for classification of psychiatric disorders.

The diagnostic categories in ICD 10 are:

- F01-F09 Mental and behavioral disorders due to known physiological conditions
- F10-F19 Mental and behavioral disorders due to psychoactive substance use
- F20- F29 Schizophrenia , Schizotypal, delusional and other non-mood psychotic disorders
- F30-F39 Mood (affective disorders)
- F40-F48 Anxiety, dissociative, stress related and other non – psychotic mental disorders
- F50-F59 Behavioral syndromes associated with physiological disturbances and physical factors
- F60-f69 Disorders of adult personality and behavior
- F70-F79 Intellectual disabilities
- F80-F89 Pervasive and specific developmental disorders
- F90-F98 Behavioral and emotional disorders with onset usually occurring in childhood and adolescence.
- F99 Unspecified mental disorder.

Diagnostic and statistical manual of mental disorders, 5th edition

The DSM 5 is published by the American Psychiatric Association. Its fifth edition was released in May 2013.

The diagnostic categories are:

- Neurodevelopment disorders
- Schizophrenia spectrum and other psychotic disorders
- Bipolar and related disorders
- Depressive disorders
- Anxiety disorders
- Obsessive- compulsive and related disorders
- Trauma and stressor related disorders
- Dissociative disorders
- Somatic symptom and related disorders
- Feeding and eating disorders
- Elimination disorders
- Sleep wake disorders
- Sexual dysfunctions
- Gender dysphoria
- Disruptive, impulse control and conduct disorders
- Substance-related and addictive disorders
- Neurocognitive disorders
- Personality disorders
- Paraphilic disorders.

In many countries the two diagnostic and classification systems are in use and so it is useful to be familiar with both.

References and further reading:

1. Diagnostic and Statistical Manual of Mental Disorders, fifth edition, Arlington, VA. American Psychiatric Association, 2013.
2. The ICD 10 classification of Mental and Behavioral Disorders. Clinical Descriptions and Diagnostic Guideliness. (1992).WHO. Bombay: Oxford University Press.

Chapter 2

Signs and symptoms of mental illness

What are mental health and mental illness?

The World Health Organization has defined health as "a state of complete physical, mental and social well being and not merely the absence of disease." It goes on to define mental health as "a state of well being in which the individual realizes his or her own abilities, can cope with the stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community".

Mental illness then is the opposite of mental health and includes a wide range of disorders in which there are disturbances involving behaviour, emotions or ways of thinking; and which may cause distress to the individual or others and affect their social and occupational functioning.

Although many signs and symptoms occur in mental illness, no single sign or symptom on its own is diagnostic or pathognomonic of a particular mental disorder.Usually, various signs and symptoms occur together to form a particular syndrome or disorder. Many of these symptoms can also occur in normal people, for example a symptom like an hallucination, which is commonly associated with mental illness, can occur in normal people,as in the experience of hearing your name being called when drifting off to sleep.

A good understanding of the many signs and symptoms that occur in mental illness is essential for the proper diagnosis of a mental disorder.

The following is a brief description of some of the signs and symptoms that can occur in mental illness, discussed under the functions and systems affected.

1. Abnormalities of appearance,movement and behaviour

(a) Physical appearance/manner of dressing

An unkempt appearance and neglect of personal hygiene can occur in schizophrenia, dementia, alcohol abuse and depression.Flashy, over-adorned

dressing and excessive makeup, on the other hand may occur in manic patients and those with histrionic personality disorder.

(b) Level of motor activity

- Hyperactivity, restlessness and the inability to sit still can occur in manic disorder, attention deficit hyperactivity disorder and in acute intoxication states.
- Psychomotor retardation with markedly reduced movements and slowed speech may occur in depression.

(c) Stereotypies

Repetitive movements, which are purposeless–that is, not goal directed – for example head banging, self-biting or repeatedly hitting one's body. They can occur in schizophrenia and mental retardation.

(d) Mannerisms

These are repetitive movements that appear to be purposeful, in other words goal directed.They may occur in schizophrenia, organic disorders and autism.

(e) Catatonic posturing

The patient maintains an abnormal position for a long time. It can occur in schizophrenia (catatonic subtype) and organic brain syndromes.

(f) Echopraxia

Is the inappropriate repetition by the patient of movements performed by the person communicating with him, for example if the examiner touches his nose the patient also touches his nose, if the examiner scratches his hand the patient scratches his hand.

(g) Stupor

The patient does not respond to commands and is immobile and mute but fully conscious. It can occur in catatonic states due to schizophrenia, depression, drug intoxication and disorders due to general medical conditions.

(h) Tics

2. These are sudden irregular repetitive movements involving a group of muscles. Occur for example inTourett's disorder.

Abnormalities of mood and affect

Mood is a subjectively experienced persistent state of feeling or emotions.Affect is the external expression of a subjectively experienced emotion and is what the observer infers from the patient's facial expression, posture and way of speaking.

Some textbooks use the terms mood and affect interchangeably, or refer only to mood which they classify as objective (what is observed by the examiner) and subjective (what the patient reports).

Abnormalities of mood and affect include:

(a) Inappropriate or incongruent affect

The patient's affect does not match what he is saying or feeling. For example, a patient laughing while saying he is saddened by the death of his mother.

(b) Labile affect

The patient has rapid and abrupt changes of affect. For example, a patient may suddenly change from cheerful laughter to bitter crying and sadness and back to uproarious laughter within short spans of time.

(c) Blunted affect

The patient's emotional response is significantly reduced in intensity.

It may occur in depression or schizophrenia.

(d) Flat affect

The patient shows very little or no emotional expression in response to external or internal emotionally charged events.This may occur in schizophrenia with negative symptoms.

(e) Depressed mood

The patient may report feeling low, sad, and worthless and feeling like crying. This can occur in depression.

(f) Elated, euphoric mood

The patient is excessively happy, self-confident and feels on top of the world. This can occur in manic states.

3. Abnormalities of speech

Speech disorders may involve the rate, flow, amount and content of speech.

(a) Rate

The patient's speech may be slow or retarded, as in depression, or it may be very fast and pressured, as in manic disorders.

(b) Abnormalities of flow and continuity of speech

Disorders which may occur in schizophrenia include:

– **Blocks** in the continuity of speech with sudden pauses.

- **Incoherence**, where there is no logical connection between one line of thought and another so that what the patient says does not make sense and is difficult to follow.
- **Flight of ideas**, where there are rapid shifts from one topic to another.
- **Echolalia**, where the patient repeats the examiner's words to a point of irrelevance.
- **Perseveration**, where there is the persistent and inappropriate repetition of speech.

(c) Abnormalities of content of speech

- **Neologisms:** these are words peculiar to the patient and not existing in any language known to the patient.
- **Word salad:** is a meaningless mixture of words. It may include neologisms or actual grammatical words, but conveys no meaning, for example a patient saying, "Many coprons you delight and nyangabgwe again slow weight it is book".This may be found in schizophrenia or dementia.The patient is usually unaware that he is not making sense.

  Speech content may also reflect underlying thought disorders like delusions.These will be dealt with under abnormalities of thought.

(d) Abnormalities in the amount of speech

The patient's speech may be copious or the patient may have poverty of speech, saying very little or be completely mute.

4. Abnormalities of thought

Thought abnormalities can affect the **form, process or flow, content or possession** of thoughts.

(a) Abnormalities of thought form

These include:-

- **Loosening of Associations**: there is no logical connection between the patient's thoughts and it is difficult for the interviewer to follow what the patient is saying.This usually occurs in schizophrenia.
- **Circumstantiality:** the patient veers off topic and introduces unnecessary details, although they eventually come to the point. Patients with circumstantiality can be taxing for a clinician pressed for time in a busy clinic as they go on and on once they start talking.

- **Flight of ideas:** the patient shifts rapidly from topic to topic. Unlike in loosening of associations, these rapid shifts are usually triggered by some cue, such as similar sounding words or some external distraction. Flight of ideas is usually characteristic of manic illness.
- **Perseveration:** this is the persistent repetition of the patient's own words to a point of irrelevance.For example, when asked what his name is, the patient answers "John" and keeps repeating "John" even when asked a completely different question.
- **Echolalia:** in echolalia the patient repeats the interviewer's words as if mimicking the interviewer. For example:

  Interviewer: "What is your name?"

  Patient: "What is your name?"

  Interviewer: "Please sit"

  Patient: "Please sit"

(b) Abnormalities of flow or stream of thoughts

These include:-

- **Thought blocking:** in thought blocking, the patient feels as if his mind has suddenly gone empty and he has lost what he was thinking about and has no other thoughts.If he was in the middle of a conversation, he stops abruptly and looks blank. This can occur in schizophrenia.
- **Poverty of thoughts:** in poverty of thoughts the patient's thoughts are impoverished and contain little information or elaboration and the patient conveys the impression of thinking very slowly or having difficulty in thinking.This can occur in depression and dementia and in some schizophrenics with negative symptoms.
- **Pressure of thoughts:** the patient's thoughts are increased in rate and amount and the thoughts appear as if they are tumbling over each other to get expressed.This may occur in manic states.

(c) Abnormalities of thought content

These include:-

Psychotic phenomena like delusions

Non-psychotic abnormalities like preoccupations, obsessions and ruminations

i ***Preoccupations***

In preoccupations the patient's thoughts keep going back to a particular subject or matter, almost to the exclusion of anything else, and may interfere with the execution of other tasks.

ii ***Obsessions***

Obsessions are repetitive thoughts, images or impulses which keep intruding into the patient's mind. These thoughts, images or impulses keep coming into the patient's mind despite the patient's efforts to resist them. The patient, however, recognizes them as his own, even though they are unwelcome.

The subject matter of the thoughts, images or impulses is usually about things which the patient finds unwelcome or unpleasant, for example concerning sex, dirt and contamination. A mother may,for example,suddenly get an impulse to stab her child with a knife she is holding.These impulses are resisted with great emotional effort.

Obsessional doubts involve repeated uncertainties about previously carried out actions, for example repeatedly checking if one closed the door.

iii ***Delusions***

Delusions are strongly held false beliefs that cannot be removed by evidence to the contrary and are out of keeping with the patient's social, cultural and educational background.

Delusions can be **bizarre** or **non-bizarre**. A bizarre delusion involves a belief in something which cannot happen in real life.For example; one patient went around mooing like a cow and believed he was born of a cow.

A non-bizarre delusion involves a belief in something that can occur in real life, for example a false belief that one has been poisoned or bewitched, or that neighbours are plotting against one.

What makes a non-bizarre delusion a delusion is not necessarily that what is believed is false, but rather the reasoning that led to the belief. For example,a patient who believes his wife is unfaithful and, when asked why he believes so, says it is because he saw a white cat in their yard,is delusional even if, on investigation,it is found that his wife is actually unfaithful.

Primary delusions arise suddenly and fully formed, out of the blue.

Secondary delusions arise out of an abnormal experience, for example a severely depressed patient developing a delusion that he has committed a great sin.

The contents of delusions are classified according to themes.Some types of delusions are:

- Grandiose delusions
- Nihilistic delusions
- Paranoid delusions
- Delusions of guilt
- Delusions of reference
- Delusions of control
- Hypochondriacal delusions.

a) Grandiose delusions: the patient may believe they are some great person,for example the president,or that they have special powers or are very rich.I have seen a lot of patients who,for example,believe they are Robert Mugabe or Osama bin Laden or some other such prominent personality.

b) Nihilistic delusion: the patient believest hat they or parts of their body,or even parts of the environment, do not exist.For example,a patient may believe that he doesn't have intestines therefore cannot eat,or may believe that he has lost everything in the world.

c) Paranoid delusions: Also called persecutory delusions, paranoid delusions involve a patient's beliefs about his relationship with other people or organizations.In the most common type, the patient is suspicious and believes that other people or organizations are out to get him or have poisoned him and so on.

d) Delusions of guilt: the patient falsely believes that he has committed a great offence or sin and needs punishment.This may occur in depression.

e) Delusions of reference: the patient believes that events or objects have special significance for him or her.For example, when he watches a program on television, he may believe that the program specifically refers to him.

f) Delusions of control: the patient believes that his thoughts, actions or feelings are not his, but recontrolled by an external agency.

g) Hypochondriacal delusions: the patient believes he has a serious illness despite repeatedly negative investigations and assurances from doctors.

The content of delusions usually reflects the patient's culture, environment and current events.For example, patients with grandiose delusions in Kenya may say they are President Uhuru while those in Uganda may say they are Museveni.

Other patients with paranoid delusions may believe they have been bewitched by a jealous neighbour who has put objects in their stomachs.

(d) Abnormalities of possession of thoughts

These include:

- Thought insertion
- Thought withdrawal
- Thought broadcasting
- Thought echo.

i Thought insertion

The patient believes that his or her thoughts have been put in their mind by some external agency or force.

ii Thought withdrawal

The patient believes that his or her thoughts are being taken out of their mind by some external agency or force.

iii Thought broadcasting

The patient believes that his or her thoughts are transmitted and known to other people through the radio, telepathy or some other medium.

iv Thought echo

The patient believes that his or her thoughts are repeated outside once they have thought them.

5. Abnormalities of perception

In simple terms, perception is the awareness of and interpretation of stimuli by a sense organ.

Illusions are misinterpretations of external stimuli

A **hallucination** is a perception without an external stimulus. Some types of hallucinations are:

- Visual hallucinations
- Auditory hallucinations
- Gustatory hallucinations
- Olfactory hallucinations
- Tactile hallucinations.

Although the type of hallucination alone is not diagnostic of any particular mental disorder, visual hallucinations are more common in psychiatric conditions of physical origin, for example in delirium. Auditory hallucinations occur in psychiatric conditions of psychological origin or physical origin. Some types of auditory hallucinations, for example hearing voices making a running commentary on one's actions or behaviour,or voices discussing a patient amongst themselves, are more characteristic of schizophrenia.

6. Abnormalities of memory

Loss of memory is called amnesia.

Retrograde amnesia refers to memory loss of events that occurred before the onset of the memory loss while **anterograde amnesia** refers to memory loss of events that occurred after the onset of the memory loss.

Confabulation is when the patient fills in gaps in memory by "remembering" events which did not actually take place.This can occur for example in Korsakoff's psychosis.

7. Abnormalities of attention and concentration **Attention** is the ability to focus on something while **concentration** is the ability to maintain that attention.

In manic conditions, both attention and concentration are impaired and the patient is easily distracted.

In depression the patient's concentration can also be impaired.

Attention and concentration can also be impaired in delirium and dementia and in anxiety states.

8. Abnormalities of consciousness

Consciousness is the state of awareness by the mind of itself and the external world. It ranges from being fully alert to being comatose.

Disturbances of consciousness include:

(a) Clouding of consciousness

The patient has reduced awareness and reacts to stimuli poorly.There is some disturbance in attention and thinking.

(b) Stupor

The patient appears conscious, with eyes open, but is mute and immobile and barely responsive to external stimulus, although they can follow objects with their eyes.They can respond to painful stimuli.It may occur in schizophrenia, catatonic type, and severe depression, mania and dissociative disorders.

(c) Torpor

The patient appears drowsy and inactive and easily falls asleep.It can occur in organic brain syndromes like delirium.

In practice

If you are not native to the country in which you are practicing, it is essential that you familiarize yourself with the local myths, idioms and cultural manifestations of illness. In most of Africa, belief in witchcraft is widespread and a patient who believes they have been bewitched or believes something has been put in their stomach by somebody with an evil eye is not necessarily delusional. She may be having differentials ranging from an anxiety disorder to adjustment disorder to malingering. . It is good practice to always probe how an "abnormal" belief came into being and to have a good understanding of the patient's sociocultural background. How you elicit a symptom matters as much as what you elicit. Don't ask for example" Do you hear voices?" and then when the patient answers in the affirmative, conclude that they have auditory hallucinations. Remember, everybody with intact hearing hears voices so you have to make yourself clear on what sort of hearing of voices you are asking about. More of that in the chapter on assessment.

Further reading

Sims, A.C.P: Symptoms in the mind: An introduction to descriptive psychopathology.

Saunders (2003). Philadelphia, USA.

WHO (2003): Mental Heath: Strengthening our Response.Fact Sheet No: 220.

Available online http://www.int/mental-health/resources/en/Advocacy.pdf.

Chapter 3

Assessment of the psychiatric patient

Introduction

One of the commonest complaints made by non-psychiatric clinicians is that taking a psychiatric history is a long and time-consuming process.However, a psychiatric history is not markedly different from any other medical history. The areas covered are almost similar; except for a few differences in areas of emphasis.The psychiatric assessment differs mainly in the sense that a mental status assessment is an essential component of the evaluation. Establishing rapport and a trusting relationship with the patient is important at the outset. Collateral history from other informants is crucial, as some patients may not be able to give a history on their own.

Preliminaries to history taking

- Where possible, the interview should be carried out in a room with adequate privacy.
- The patient should be made as comfortable as possible.
- Introduce yourself to the patient by name and explain the purpose of the interview.
- If the patient is the one giving the history, allow them to give the history in their own words as far as possible.

The format of the psychiatric history

Different books may give slightly different formats for the psychiatric history.Practise using one format which covers all the information you need to know.The following is a suggested format:

- Identifying/ demographic data
- Mode of referral
- Informant

- Chief complaints by patient, or allegation by informant if not the patient
- History of presenting the illness
- Psychiatric review of symptoms
- Past medical/ surgical history
- Past psychiatric history
- Forensic history
- Family history
- Personal/ social history
- Antenatal history
- Infancy, early childhood
- Schooling
- Employment history
- Sexual history
- Marital history: spouse, children
- Alcohol/ substance use history
- Abuse history

- Premorbid personality
- Reliability of the information.

a) Identifying/ demographic data

At a minimum this should include the name of the patient, age, sex, marital status, level of education and educational status. Other information can include nationality, religion, and place of residence.

b) The source of referral

It is important to state whether a patient has come to the clinic as a self-referral or been referred or brought by others, for example by police,relatives or, if a minor, by a parent or guardian.

c) Informant

State whether the patient is the one giving the history; in which case it is stated as the patient's complaints or, if informant is somebody other than the patient, state how they relate to the patient and write down the complaint as allegations.

d) Chief complaint

This should be recorded in the patient's or complainant's own words if possible.

If the patient is not the one giving the complaint, elicit the patient's response to the allegations and note it down.

e) History of presenting illness

The mainf eatures of the history of the presenting illness are:

- Mode of onset
- Duration of symptoms
- Progression of symptoms
- Any alleviating or exacerbating factors
- Any linkage with significant events in patient's life
- Any interventions made,like seeking treatment or treating oneself, and the effect of that treatment
- The effect of the illness on the patient's ability to carry out activities of daily living and his usual duties and impact on social life.
- What the patient thinks is the cause of his problem.

  In a lot of cases the patient might not be able to give a full, proper or reliable history and additional history from another informant is necessary.Even when the patient gives a seemingly full history, it is important to obtain additional history from other sources.

If information is to be obtained from another informant, it is important to get the patient's consent where possible.

f) Psychiatric review of symptoms

The Psychiatric review of symptoms screens for symptoms of the main categories of psychiatric illnesses. If not already elaborated in the history of the presenting illness, ask about psychotic symptoms, mood symptoms, anxiety symptoms, substance use, somatoform and eating symptoms, cognitive symptoms and symptoms suggestive of personality disorder.

g) Past medical /surgical history

Obtain history of past medical and surgical illnesses, admissions, type of treatment received, response and duration of illness.

The past illnesses are recorded in chronological order. In a patient with multiple admissions it may be enough to ask about the first and last admissions.

h) Past psychiatric history

Obtain a history of past psychiatric illnesses, treatment and outcome. If there are multiple admissions it may be enough to record history of first and last admissions only.

i) Forensic history

Inquire about any brushes with the law and the outcome.

j) Family history

Ask about parents, if alive, their ages, occupation, illnesses, how they get on and whether divorced or not and the patient's relationship to each of them.

If dead, record the cause of death, when they died and how the patient reacted to the death.

Ask about siblings, their names, marital status, and level of education, occupation and relationship with the patient.

Ask about any illness amongst family members, especially illness like epilepsy, any psychiatric illness, or any suicides in the family.

Ask about any history of substance abuse amongst family members.

k) Personal/ social history

The depth of the history taken will depend on the presenting problem. Although it is useful to cover all aspects of personal history,it may not be very helpful to take the antenatal history in an eighty-year-old man who has hitherto been in good health with no previous psychiatric problem.

Areas covered in the personal history include:

- Antenatal history
- Birth and postnatal history
- Early childhood and development
- School history
- Occupational history

  Sexual history

- Marital history
- Drug/ substance use history
- Use of leisure time and other social activities
- Abuse history:ask about any history of physical or sexual abuse
- Current living circumstances: housing, social support.

i Antenatal history

This can be of importance, especially in disorders usually first diagnosed in infancy and childhood, for example intellectual disability (mental retardation), some of which might be caused by antenatal insults.

Inquire about the mother's health during pregnancy, clinic attendance, and whether pregnancy was wanted.

ii Birth and postnatal history

- Whether delivery was at term
- Mode of delivery
- Any problems during labour and delivery
- Any problems after birth.

iii Early childhood and development

Enquire about:

- Childhood immunisation
- Illness in infancy and early childhood
- Developmental milestones – sitting, standing, walking, talking and so on.

iv Schooling history

- Level of education
- Age of beginning school
- Progression through school–primary, secondary, tertiary.
- Ask about academic performance,reason for repeating classes if repeated, any disciplinary problems in school, relationships with peers and involvement in extra-curricular activities.

v Occupational (work) history

- Jobs held from first to current or last
- Reasons for changing jobs
- Job satisfaction
- Relationship with co-workers.

vi Sexual history

Take the sexual history if there is concern about sexual life or the patient presents with a sexual problem.

Enquire about:

- Age at first sexual contact,whether it was satisfactory or not
- Source of information about sexual matters
- Number of sexual partners
- Attitudes towards sexual matters.

vii Marital history

- Age at marriage
- How long had they known each other?
- Quality of relationship,any difficulties and conflicts
- Reason for divorce or separation, if any.

vii Drug/substance use history

Does the patient smoke cigarettes? Does the patient use any illegal drugs? Does patient use alcohol?

If answer is yes, probe further

- How often do they use it?
- How much do they use per sitting/session?
- How do they obtain it?
- Why did they start using it?
- Do they think its use is a problem?
- Do they take it alone or in company?

- Do they mix or use more than one substance at the same time?
- What is the route of use?

Use screening tools if suspicion of substance abuse, for example CAGE or AUDIT for alcohol.

viii Use of leisure time and other social activities

Enquire about how the patient spends his leisure time. Hobbies? Any involvement in sports or religious activities?

ix Current living circumstances

Where does patient live? Housing?

With whom does the patient stay?

(l) Premorbid personality

The patient may not be able to adequately or reliably give an account of his premorbid personality and hence it is important to interview the patient and also get an account from a close relative or other person who knows the patient well.

- Ask patient to describe him/herself, what sort of person they are.
- Are they outgoing or reserved?
- Does he/she have a lot of friends?
- What sort of leisure activities does he/she engage in?
- What are his attitudes towards moral issues such as sex or religion?
- What is his predominant mood–is he/she usually a worrier, cheerful, carefree, and so on?

(m) Reliability of history

Make a comment on the reliability of the information obtained.

Mental status assessment

The mental state examination assesses the patient's state of mental functioning at the time you are seeing the patient. Being able to do a proper mental status assessment is an essential skill for making a reliable psychiatric diagnosis, just like the ability to elicit the signs and symptoms of mental illness.

The mental status examination starts the moment you come into contact with the

patient. As you take the history, you will be getting some signs and symptoms of the mental state but this should still be recorded in a standard order as this helps you to be organized and to not forget to elicit some important symptoms.

A common mistake made by beginners is to place symptoms that a patient experienced in the end which he tells you while giving the history under mental state assessment findings. For example, if a patient tells you he was hearing voices the previous day, but is no longer hearing voices at the time you are assessing him, then those auditory hallucinations are described under the history of the presenting illness and not under the current mental state assessment.

As a beginner, it is necessary to practice carrying out the full mental status assessment including cognition, but with experience one can concentrate on the most relevant parts depending on the presenting complaints and still come to a proper diagnosis.

(a) Appearance and behaviour

Under appearance, describe the patient's physical appearance, mode of dressing, grooming and facial expression.Note any striking or peculiar features. His/her attitude to the examiner is noted, for example, if cooperative, hostile, unconcerned and indifferent, and so on. A note is made of the patient's behavior and movements.

(b) Speech

Assess:

- Rate of speech (fast, slow,pressured)
- Tone
- Volume
- Structure.

(c) Mood/Affect

The distinction between mood and affect has already been described in the section on signs and symptoms.

To assess the mood, ask the patient how he/she feels. Ask direct questions like:

- How do you feel in yourself?
- How is your mood?

Record the response in the patient's own words, for example, "I am fine".

The affect is observed by the examiner and inferred from the patient's external facial appearance, body posture and movement.Affect can be described as:

- Incongruent
- Labile
- Flat
- Blunt
- Shallow.

(d) Thoughts

- Assess the form of thoughts
- Content
- Any abnormalities of possession of thoughts.

i Thought form

Assess the rate.

- Does the patient have slowed thoughts? Thought retardation?
- Does the patient have rapid shifts from one idea to another– flight of ideas?
- Does he have sudden stops and describe his mind having gone blank as if emptied of thoughts–thought blocking?
- Are patient's thoughts shallow, with little content or elaboration of ideas – poverty of thoughts?
- Does he reply to questions in an oblique manner without seeming to come to the point –tangentiality?
- Does the patient reply to questions in around about manner with many digressions and delays in reaching the point, although he eventually comes to the point–circumstantiality?

ii Thought content

Delusions: Sometimes delusional thinking will have been clear from the history taking but sometimes it will be necessary to inquire about delusional thinking directly.

Questions which can help elicit delusions include:

- Do you feel there are people who are out to harm you in any way?

- Does the radio or TV talk specifically about you?
- How do you feel about yourself?
- How is your relationship with other people?
- Have you noticed any changes in your body?

Suicidal / homicidal ideation: inquire about suicidal and homicidal ideation.

iii ***Disorders of possession of thoughts***

These may also come out during the interview.However if suspected, useful questions include:

- Have you ever felt that people are putting thoughts in your mind?
- Have you ever felt that people are removing thoughts from your mind?
- Have you ever felt that your thoughts are not yours only, but are broadcasted or known to other people?

Obsessions: Ask the patient if there are any thoughts that keep coming into his or her mind despite his or her effort to avoid them?

If yes, ask what those thoughts are about?

(e) Perception

The patient may give a history of hearing voices or hallucinatory experiences or sometimes this may have been inferred from the patient's behavior if the patient, during the interview, behaves as if engaging in a conversation with an unseen person. However, most of the time hallucinations will have to be directly asked about.Tact has to be exercised when asking about hallucinations because some patients may feel offended. Introduce the topic with a statement like: "sometimes when people are distressed or disturbed they might experience unusual happenings, like hearing voices which nobody else around them can hear.Has this ever happened to you?"

Though it seems like it is easy to ask about hallucinations, most beginners ask questions which are prone to ambiguous interpretation for example:

"Do you hear voices when you are alone?"

"Do you hear voices talking inside your head?"

This latter one is a wrong question because, by definition, a hallucination must have the quality of a real percept. The patient must be aware that the hallucinations represent external reality. Inquire about hallucinations in all the sensory modalities

that is visual, auditory, tactile, olfactory and gustatory.

Ask questionslike:

"Do you hear voices when there is nobody else around, or which other people can't hear?"

"Do you see unusual things or things which other people can't see?"

(f) Cognitive assessment

Cognitive status assessment assesses

- Orientation
- Attention and concentration
- Memory
- Intelligence
- Judgement
- Abstract thinking
- Insight.

i Orientation

Orientation is usually assessed in three modalities

- Time
- Place
- Person.

Ask about orientation with tact.Some patients may feel belittled or offended if you abruptly start asking them if they know what time it is or where they are. Explain to them that you are going to ask them some questions which look simple but that are useful for the assessment, then ask them what time it is and if they know where they are.The patient does not need to know the exact time but will be oriented if, for example, they can give an approximation, for instance knowing it is in the morning or late afternoon.

From the introductory part of the interview one may have determined whether the patient is oriented in person. If so, there is no need to ask the patient's name.

ii ***Attention and concentration***

One is usually able to get a good idea of the patient's attention and concentration during the course of the history-taking interview. More formal testing is done using tests like the serial subtraction of seven from one hundred. If the serial sevens test is too difficult for the patient,he or she can be given a simpler test like counting the months of the year backwards or simpler serial subtractions, like subtracting two from twenty.

iii ***Memory***

Memory can be conveniently divided for assessment into:

- Immediate memory
- Recent memory
- Remote memory.

Immediate memory: the patient is asked to repeat a name and address. The name and address is repeated until the patient is able to repeat them.

Recent memory: the patient is asked about recent events in their life, for example what they ate for breakfast (you must only ask this if you know the answer) or where they were yesterday or about recent events that have been in the news.

Remote memory: this can be assessed from the patient's ability to recall personal historical events in their life, for example where they went to school. Questions can also be asked about important historical events.

iv. ***Intelligence***

A gross estimation of the patient's level of intellectual functioning may be obtained during the course of the interview by noting how the patient answers questions and discusses issues; including use of language and vocabulary.

Taking into account the patient's level of education, general questions aimed at gauging the patient's level of intelligence may be:

What is the name of the President?

What is the name of the capital city?

Name two political parties.

The questions should be adapted to suit the patient's level of education. A patient with graduate-level education may be offended by such simple questions.