Psychiatry an Overview
Dr. Alok Bajpai
Humanities and social science
Indian Institute of Technology, Kanpur

Module-02
Diagnostic Process in Psychiatry
Lecture-06
Mental StatusExamination-1&2

Welcome to this second week of psychiatry and overview. In the last week we looked at the basis of human behavior briefly, we just did a bird's-eye view of the whole thing. Now this week we will try to look at the tools which we use in to assess people in the clinical setting clinical setting or research in behavior. So the basis of this is what we call a mental status examination.

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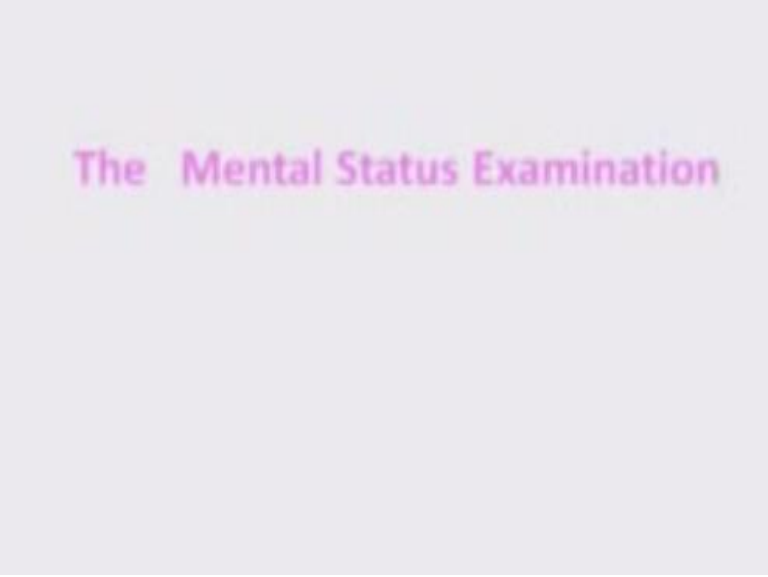

Well obviously we have to interact with people to judge whether their behavior is normal or not normal, people abroad to psychiatrist or a clinical psychologist for to be assessed whether they are behaving normally or abnormally. Now the basis of decision of normal and abnormal we will talk about in the other part when we talk about classification.

But how do we without using the technology how do we judge whether the person is having some problem or not and like in other medical examination, obviously it will be useful for people who are into clinical setting, but also for people to understand how psychiatrists reach a decision of whether the person has a illness or not, or it is just a variant of normal behavior.

The process of this is called a mental status examination. Now this mental status examination has certain descriptions of human behavior which indicate the state of the mind. And that are the same things which everybody has like thought, like emotions, like behavior, the appearance, the memory.

But how do we assesses is, is and that the difference and the range of behavior, the range of experiences with the mind is going undergoing the type of experiences are called phenomena. So phenomenology is the window by which we can assess the person and reach a decision whether the person is having a problem or not, it kept, it comes from philosophy actually existential philosophy calls those person.

Others who divides this phenomenology and we still remains the standard tool of a clinical assessment, which a psychiatrist should be well trained into like a physician should be well trained into auscultation, palpation, observation. Similarly a psychologist and a psychiatrist, but for its good for other people also who are doing this courses from other disciplines to look into the process.

Because obviously it is a framework with psychology and philosophy has provided us and it helps in understanding into the different mental status. So mental status examination.

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To the first and foremost you observe you listen and then you ask not necessarily in this order, because it will otherwise make a very cut and dry exercise which cannot work with you human beings. So all these three things sometimes have to be done simultaneously, sometimes in sequence, sometimes parallel.

And this is the human skill which a psychiatrist and a psychologist are supposed to develop a mental state examination part of which defines the normal behavior, part of which defines the abnormal states of mine.

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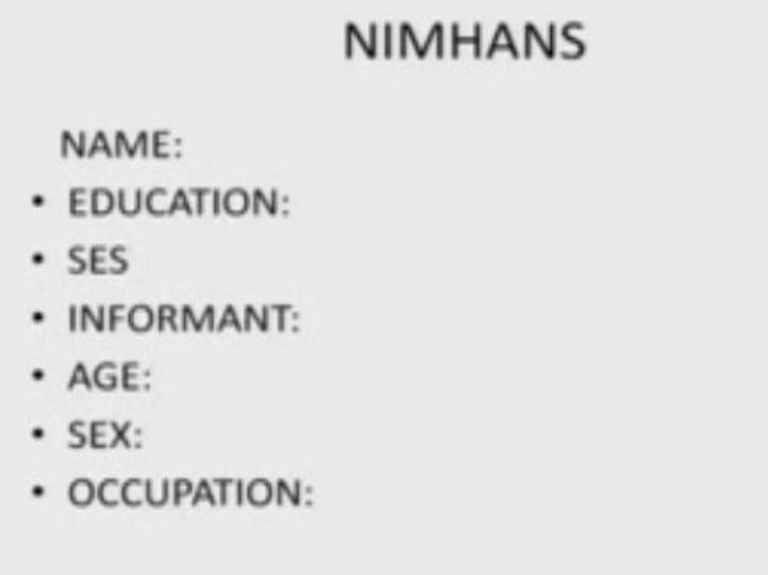

This is a perform of which I will just run through developed by Nimhans national institute of mental health and neurosciences on the premier institute of psychiatry and neurosciences in India. So obviously when you introduce yourself to somebody you have to ask the name introduce yourself, ask the name, education status, socio economical status.

If somebody is accompanying the person and I am not calling that person a patient still, because we haven't established whether that person is patient or not. They are normally brought to us everybody is got to a psychiatric clinic is brought with the problem.

Now this problem is a altered behavior which may be causing disruption in the adjustment with the people or within himself or the person is not performing optimally, they can come up with common problems. So you check the – who is the informant, it would be your family member or friend.

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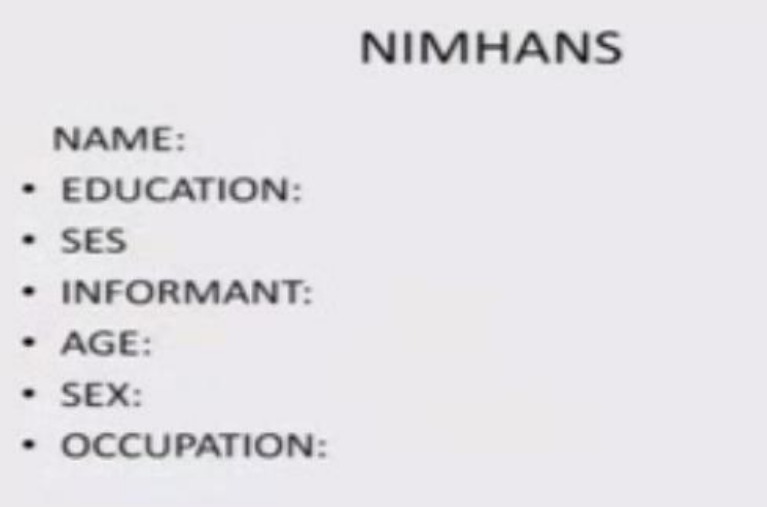

Age of the person, sex of the person, and occupation. This demographic data broadly gives you a context, as I said in the last slide in previous lectures what makes us human is not the size of the brain or just the basic activities that all animals do. It is the context of your behavior which actually makes us define whether it's normal or abnormal.

A soldier firing on the border in a war may be normal, but a soldier who stands suddenly enters a restaurant and starts firing will be abnormal. So the context of human behavior is very important and that we all should remember whether we are in research, or in teaching, or in interactions in your business and so this is something which we have to always know.

So this demographic data, suppose a person who let me give you an example suppose a person who is not going to school is coming from a village, and suddenly enters your room and has not trained in English obviously, and starts talking English with a broken English here and there, which is unusual for the person. So this background information will help you in understanding the context.

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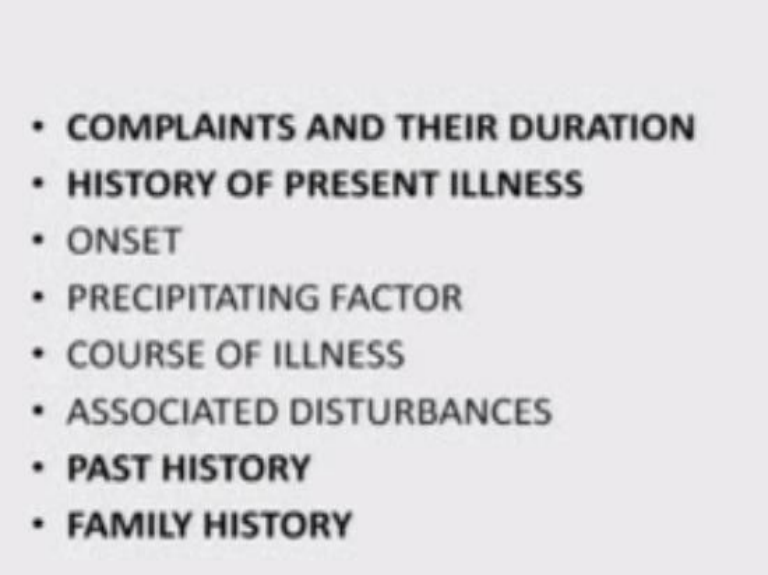

So everybody will come with a complaint, but -- so what are the common complaints people come up with, maybe if they bring a teenager to you and say that he is not studying, he is not going to school that maybe considered an abnormal behavior by the parents.

So when we are looking at the phenomenology we are looking at the expression of the behavior of what is actually happening. At this point we will not be too bothered about why it is happening. So if somebody comes and tells you that the person is not going to the school and that kid tells you that I am not interested in the studies, that is the phenomena the lack of interest.

Now not going to school maybe, because of a broken leg or lack of interest maybe because of the maybe he has a week eye and he is not able to see the board. That we will have to discern as we go along collecting the history, but before that let me tell you about an experiment.

A professor took is a couple of students to a psychiatric hospital and they all complained that they were hearing voices which is called hallucinations in the absence of any true source of sound in the vicinity. And they all are giving diagnosis, but they all offending

it. So the difficulty is very difficult to understand if a person is complaining the real cause unless we really go deep, but that is the second level of enquiry.

The first level of enquiry is what is the complaint somebody who is a quiet person and suddenly becomes very abusive they may be brought with this complaint. So the first thing is the complaint itself, second you will have to check what is the history it's in days, in hours, in months or it has been for years. How did it start is the onset, because some illnesses start and grow slowly which is a insidious onset all medical students will know this.

And some illnesses may start acutely, acutely means sudden onset. Now this sudden onset may have different causes not that all assess have to start insidious, but some long-term illnesses can suddenly they go slow and starts slowly and progress, whether there is a precipitating factors, whether the illness is started with some factor which has happened in the environment, or body of physical illness, mental illness, a trauma or some other event.

Because some of this illnesses psychiatry illnesses as we – you will learn later, have very clear-cut onset with a environmental stress, some of the medical illnesses can cause psychiatry illnesses. Course of illness, whether once it has started is it progressive, is it worsening, the symptoms are worsening or after worsening suddenly they have reached a plateau and they're going on like that only without any further change intensity or they're improving.

Or it's the continuous illness for the duration whatever they have told you or it is a episodic illness like it happens, it switches on, it has a certain course then it automatically improve which we call remission. Now these are important factors in deciding on what illness we are talking about, what mental state we are talking about, whether we are talking about a state of the mind which and where it is suddenly -- it has suddenly gone into one state and it is never coming back to the original state of the mind.

Or it is like a phase that for phase it the disruption is there and that becomes all right, like for some children like a illness called mental retardation, it is a -- it happens and then it happens it is just that gap between intelligence and age continues. Whereas as something like dementia in old age where there is a progressive decline it's a very, very progressive illness, a bipolar illness mostly it's a episodic illness right.

Along with it we have to look at what impact it is having in the life of the person, in the work, in the relationships, in the normal flow of life which is a hallmark of normalcy. Now one person normalcy may not with other person's normalcy, a sports person doing a marathon every day is normal for him, but it may not be normal for a office clerk.

So depending on their context which you get from the demographic information which you have already collected what exactly this set of symptoms is doing and it pass history of illness, so this you will have to check whether if it's a continuous illness, you will have to check from what time it is started, whether there was any illness or disturbance before that, but if it is an episodic illness again.

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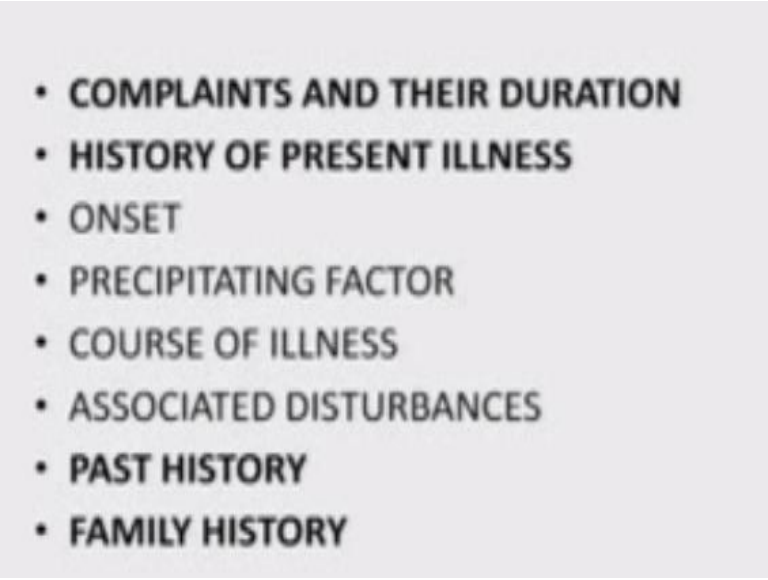

The past history would be before the first episode. If you take a present episode somebody tells you this person is deserved for 15 days, you will have to really ask whether they have been previous episodes like this, and then go back to the first whatever information you can gather and family history, because that's we have talked about genetics.

So if genetics, the behavior of human being is like a template which comes from you're gene, the illnesses will describe when we talk about illnesses, also have their genetic predisposition and it is more or less established that the certain illnesses they're like run in genes.

And it is not necessarily that every person will have it, but if there is a illness suppose for a sudden illness a normal person in whose family there has been no illness the risk is 1%. And if somebody in the family has had a illness the risk will go up to 10%. So if somebody in the family has had a similar illness you can narrow down your search.

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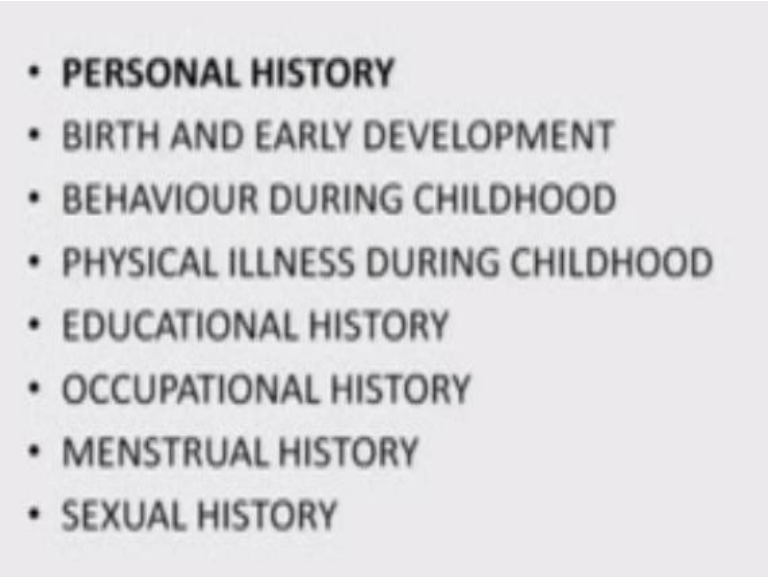

Personal history in birth and early development, whether the person was normally intelligent and development was normal, whether there was a predisposition that temperament during the childhood which has really supposed, were lot of linkage what we call externalizing syndrome, disturbances in childhood because of the environment or because of illnesses or because of genetics or epigenetic.

Lot of this kids who have disturbances in the developmental phase are known to develop psychiatry illnesses as the grow, because one thing which we should mention it here, is that the brain once it starts developing within the womb initially grows number of neurons grow much higher than what is required till a certain age here on teenage of 14, 15, 16.

And then there is a pruning which just starts in the brain, and the pruning is that the synapses decrease till around, it starts around 16, 17 then all its life it -- the brain keeps pruning along with its neuroplasticity, neuroplasticity means that if the brain is damaged it will always try to reorganize and restructure itself.

Some neurons which are specialized can always take over the function of the other neuron, it is very well known. But largely the pruning happens and brain shrinks, but it does not shrink enough for most people to lose their intelligence or their skills. It shrinks more in some other illnesses and that's why illnesses come this is the developmental model of illnesses we are – the brain shrinks more than required.

But if you look at the development of the brain with this 10^11 neurons is like environment challenges the brain, the brain response to the environment, and in this critical dialectics the brain forms new and new networks and synapses. And that is what learning is all about.

So once brain is challenged with something with the environment the brain tries to overcome it in the process forms new synapses, new skills, new memories moves on till the next challenge comes. So these are critical period of developments which keep

happening at various ages and psychology also defines a lot of the development like people like paige and fraud they give various theories of critical development.

Probably what they were telling psychologically is the corresponding critical development of brain during teenager when the hormonal changes are happening. So it is important to know what was happening during the behavior and what was the environment during childhood, because that will tell us whether the brain successfully resolve those critical challenges and critical period and form the normal synapses like everybody else.

The good thing is that, because normalcy is also defined by a common pattern of behavior statistically normal most people are behaving a certain way. That means the brain has this synapse formation in brain, the network formation, the brain is actually the pattern of response to the environment which most people develop their maybe range of aberration and change in behavior.

But most people would be respond to certain stimuli in the same way that is the commonality of human race, that commonality is the normalcy of the human race. So within that commonality there may be variation, but any aberration of development suppose during a certain critical development phase the environment is not conducive, suppose in the first two years of life the brain is not receiving the trust and security and the love and warmth of from the environment.

It will become anxious, because the brain will always be insecure and these insecurities are one which people show later in life. Now this is more or less a very, very robust thing which we have learned over time. Physical illnesses also disrupt, educational history which is obviously related to the growth of the brain, occupational history, menstrual history, sexually history all these things which go on in making a normal person.

But this is important, because any aberration we will find in any of these should be correlated later on to the abnormal behavior may not necessarily be causal, may not

necessarily be directly linked to why it is happening, but definitely to contributing to this illness.

Because we know psychiatric illnesses or abnormal behavior do not have a single factor rarely they have a single factor that okay, is like this event. Now you have a injury on your leg and your bone is broken is not like that. The brain bone when it breaks it may have multiply you are tendency to develop a illness, you're environmentally stressed, you're genetic predisposition, your stress.

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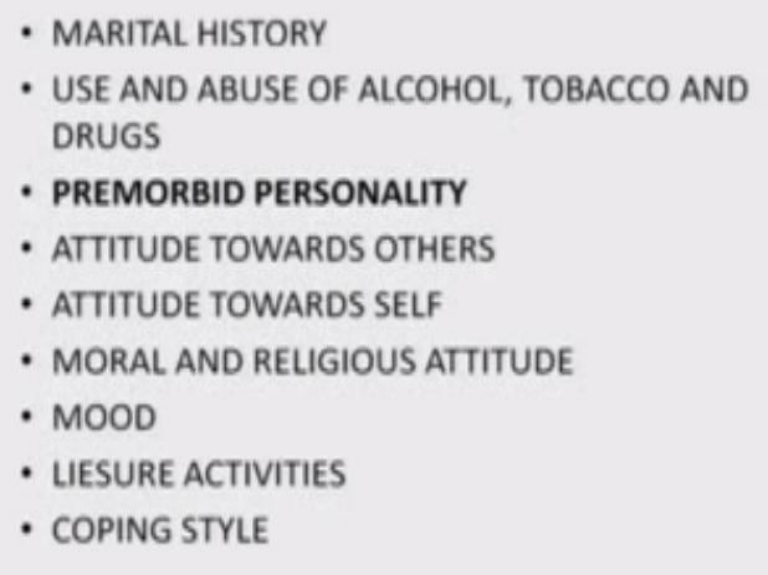

Okay marital history use and abuse of drugs, because drugs are chemicals which we very well know are disruptive into the brain mechanism, alcohol, cannabis, cocaine all of them. Premorbid personality which includes attitude towards others, attitude towards self, moral religious attitude, mood leisure activities, and coping a style. All these are important.

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Because all these things actually contribute to making a person. Now when we know, we get all this history and meanwhile when we talk about mental status examination while history taking in mental status examination may not be separate. All though for convenience sake we are putting it in our categorized manner.

But while we are gathering information we are we are doing a lot of mental status examination maybe sometimes patient is lots there, something is the informant relaxing, but we're also at the same time observing we are looking, we are being a general behavior.

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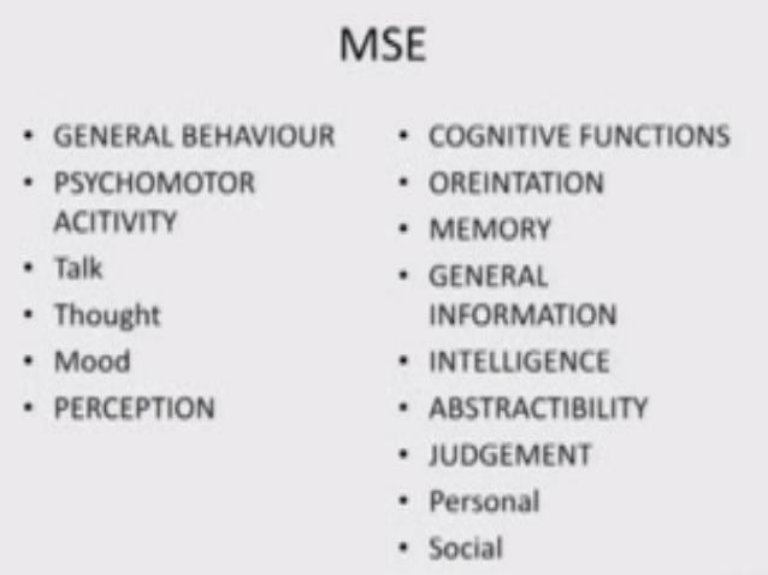

We are gathering this thought process is the religious belief, he is working style with. So you understand this psychiatry examination is a time-consuming process, and the first and foremost is we should be with the person not deal with the person as from top-down thinking of as a patient, but also try to look at the person that will help you take a clear decision.

So once you have taken this history out of this history and other things we can get to doing what we call a mental status examination.

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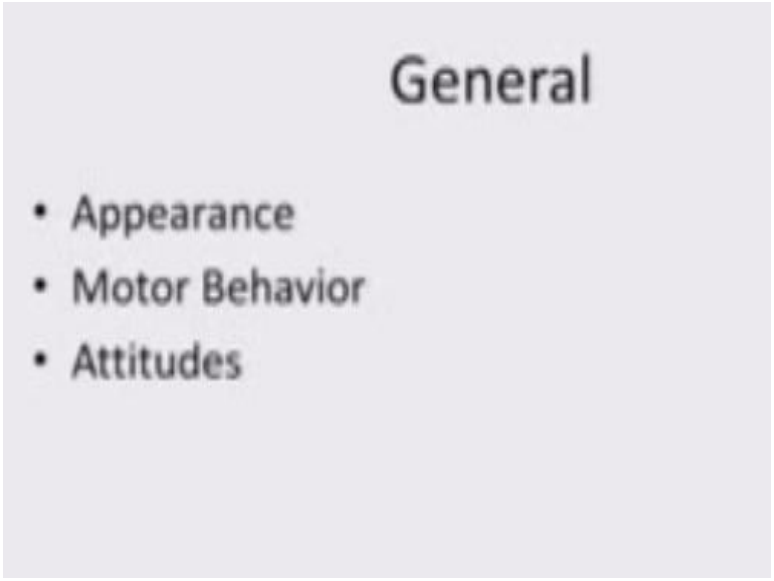

So what do we look at it first in a given society there are certain ways of dressing, there are certain ways of behaving, there certain ways of addressing. So you look at the general thing you look at the appearance of the person given the education status, given the background, given the socio economical data given is religious belief, given his social cultural belief, there is a certain behavior and appearance which is expected. So that will – there is a first thing which will tell you whether.

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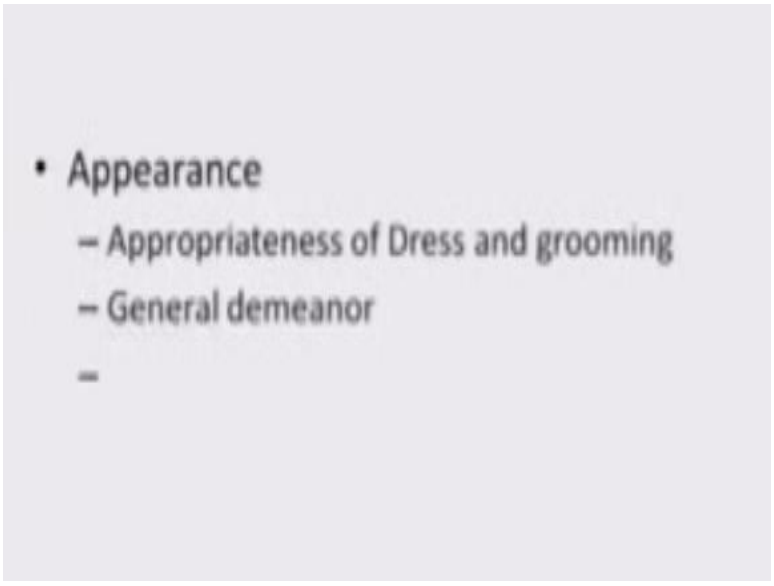

The person isn't sync with the environment or not.

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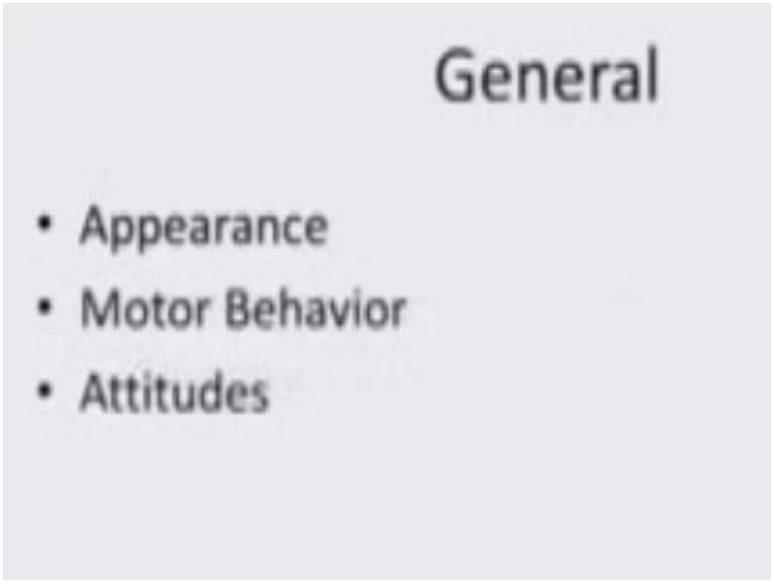

Second what you will have to look at is at the activity level and the attitudes.

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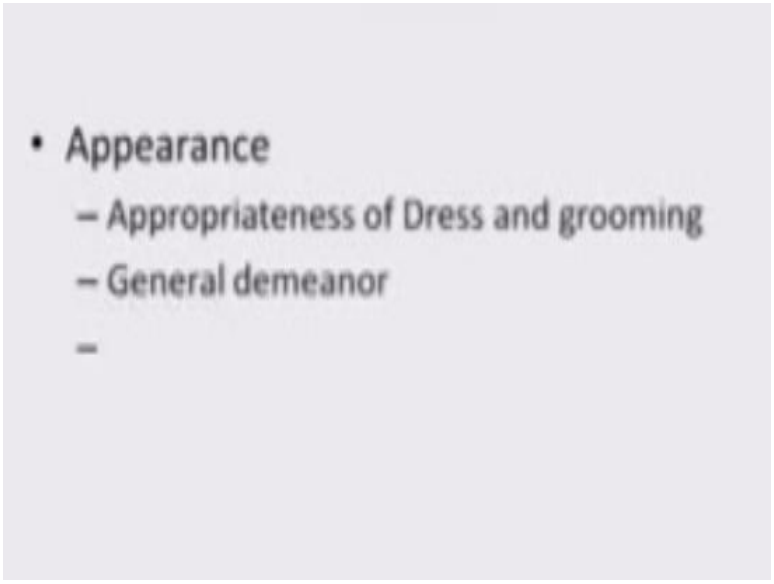

Like an appearance appropriateness of dress as I said general demeanor, if a normal person who has been normal and those are suddenly bounces into your room and is very aggressive and threatening without any reason without any background of knowing you obviously there could be a sign of an abnormal behavior.

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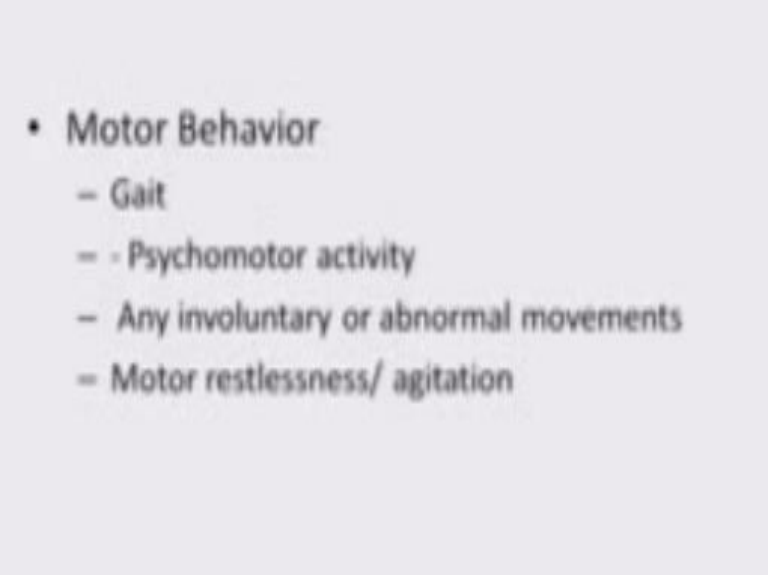

When you talking a motor behavior you see the way people walk, there is all common sense thing, but you have to develop eyes to know all that. You see the paper where people walk where some people walk very grandiosely, some people are you know that hottie walk was there, some people are very, very timid, hesitant there may be a problem with walk with, because of a neurological thing.

Like a Parkinson's patient a psychiatry patient may have a neurological problem as a very, very different typical walk short shuffling steps or somebody with the frontal lobe damage has a different type of walk. There is a problem with initiation psychomotor activity, there is a motor activity and there is a psychomotor activity.

Motor activity is like somebody who is sitting on the chair in front of you and there is no reason to be anxious except for his internal reasons of what he is thinking, he is very

fidgety touching these things, clasp catching the edge of the chair or tremors these are all motor activity restlessness, hesitation.

Whereas psychomotor activities are certain goal directed activity all of us when we sit and talk or standard talk have certain amount of psychomotor activity going on within us all of us do it unconsciously. Because you see when I am talking I am moving my hand, so why am I moving if you ask me immediately I may not have answer, but that is that habit or the way I have evolved.

But if psychomotor activity is drastically reduced or it is drastically increased like a person who comes and says and suddenly starts fiddling takes and pen and paper, he starts writing without provocation, or without being asked to.

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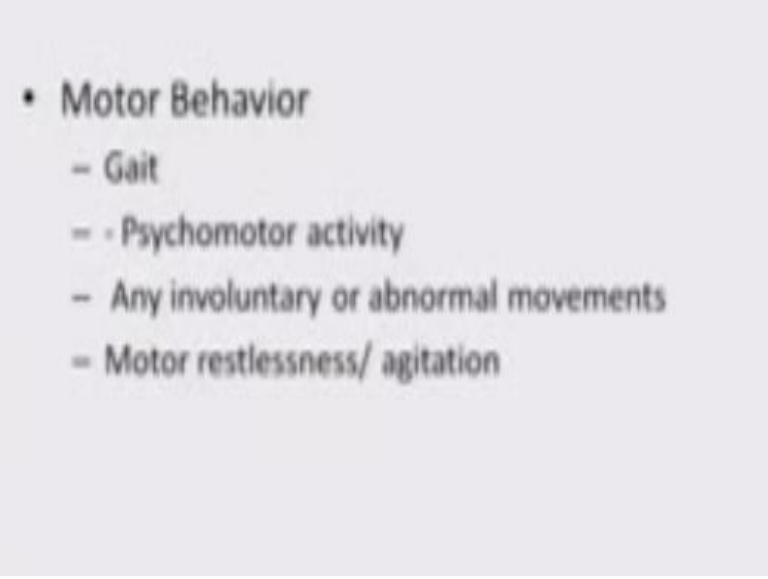

Or he starts fiddling with your paperweight or suddenly goes and switch on or put source of light that is a sign of increased psychomotor activity, which is the hallmark of illnesses called mania increase agitation can happen in neurological illnesses like Parkinson's or cerebella dysfunctions, or anxiety or any other abnormal movements lot of neurological

illnesses have like in Huntington's chorea they were suddenly dance like movement or enrolling travels in Parkinson's or they maybe tics sudden jerky movements episodic jerky movements of certain areas of body.

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All this has to be observed, but what is also important now how will you judge all this, the first and foremost is obviously establishing a rapport with the patient. What is a rapport, a rapport between any two person is where people are ready to share things with each other. Now if a person doesn't form a rapport with you obviously your rest of the interview will not and often people find this difficult.

If you do not see whether the rapport is good or bad and then later on you say, you could not gather information it is because of the lack of rapport. A lack of rapport itself may be a sign of abnormality, because ideally when they're broad to doctor say, they you're supposed to tell things. So if a person decides not to tell it's like difficulty building rapport.

And some people will walk and become very friendly with you to both ends may be a sign of illness like in mania patient who has mania was dis-inhibited and talking too

much and it just comes, it becomes very friendly with you and you will find it very easy to find and established rapport.

But if somebody tells you that 15 days back he was not like this. So you will find this is a sign of abnormality, so having said this, so rapport building may be normal, but we all with experience in dealing with people we know that a gesture of smile, at how are you talking about other things bills are rapport.

When you find things of common interest eye to eye contact, whether the person looks into your eyes and then talks is a good sign on a window, eyes are windows to mind it is very true. But when as to really learn to look into that window eye to eye contact is something which can tell you whether the person is actually inclined to talk to you. And eyes can tell you it can differentiate between lots of illnesses.

Because you know what anxious eyes look like, and you know that were depression is there the people are looked down, downcast eyes you can – and then it goes on with your face where isn't something called negative schizophrenia where the person is totally blank inside not totally blank, but it's in the total revolution, not interested in talking flat mind, not many thoughts in the mind is still the eyes may not be done cost, they may be normal.

That is one of the fine settle differentiation, but so eye to eye contact is poor or good or fleeting, because a maniac the patient with mania, so what do you call a mania, I just uttered this word is different from people having mania. So maniac is a literary some metaphorical term, but it has become maniac.

But mania has a illness is different a person with mania will have fleeting eye to eye contact, because he will not be able to put attention into one thing where the normal person would may have slight distraction here and there, but largely will look at you.

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So rapport and eye to eye contact will give an idea of the mind state of the person whether he is interested, he is there talking to you or not.

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Speech so after eyes what do you – the only way we know what the other person is thinking his thoughts and thoughts are expressed to speech atleast in most conditions

when we are talking. The other ways of expressing your thoughts by painting and writing and all, but they are -- those are different things.

When we are talking to a person you will look at this speech, so what do you look at in the speech, you look at the rate whether the person is really what, what rate these words are coming out, especially in many other -- people are very valuable, their control is gone and they will be uttering the whole barrage of words.

Whereas in depression even the normal output of words would have been decreased in schizophrenia in undifferentiated type of schizophrenia where people do not have much verbal output. Spontaneity whether you have to prod the person to talk or the person would talk and is willing to share the information on his own.

We know there are some people who talk spontaneously some people have to prod and intro words often don't talk and they have to be asked and told whether there is a personality issue, whether these are the illness depends on whether he has become like this or he was always like this as we have discussed.

Whether the thing is continuing from part of the personality or intonation and what torn the person talks that is the reflection of the emotion irritability, anger, sadness we can we can make it out from the – if similarly volumes all these things are not separate you do not have to go one by one and check rate or check spontaneity or check intonation or check what.

With the overall output you can judge it is a matter of a skill again it is a matter of exposure to various people to differentiate between what type of speech and one good book which is there is called fishes book FISH’S it's the book on phenomenology which gives a good description of all this.

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But largely speech, eye-to-eye contact, rapport, general opinions behavior in keeping with the context and in keeping with the personality, in keeping with the background with the previous history which you already have and the personality it will give you idea whether all this is going in the right direction, in which is what we call normal or is it something else.

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Then what you have to judge that there are illnesses which are in psychiatry which are basically disorder of mood what we call bipolar mood disorder, or their disorders of thought and perception, or their disorders of cognition, or all of them existing together. So once this general thing of speech and appearance behavior and rapport and eye to eye contact will give you an indicator of what exactly is happening.

But then you have to still go deeper and really find out mood, mood versus affect. Mood is a more or less slightly longer sustained phase of emotion; affect is slightly if you take it in a cross-section. So mood generally is the moody person means what we think, but that is a common sense thing, is a depressed person means that largely his mood remains depressed.

He is a happy person largely his mood remains happy. Affect maybe cross sectional, when we are talking for one hour he may be happy at that time or sad. So we have to differentiate between that when somebody says this person is extremely happy.

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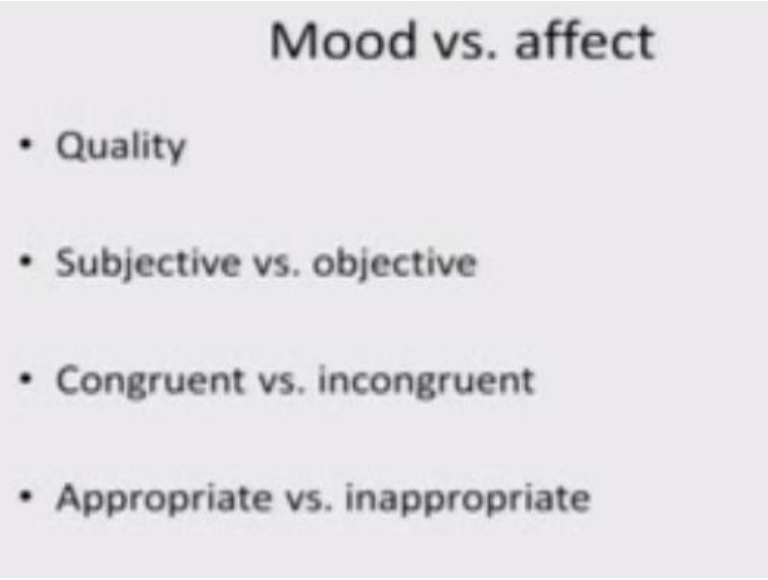

So what you have to check whether he is happy now in the last 3, 4 hours, one day or generally he is a happy person for last one week. So when we assist we normally talk of immediate cross section what is happening now which is affect, and what is happening to his mood in the last one week roughly.

So I would trade the thing, there is no scientific proof to it, but largely it remains. So what we have to look at the quality, you know, what are the quality of moods we all know is the old range of human emotion. All though we know they are primary emotions, but they are secondary complex emotions like love and altruism and all that.

For primary are angry, fearful, sad, happy, enrage these are the large, largely. Now sometimes what will happen in the same interview you will find lot of fluctuating moods which is also fine, because you do not have to fit the person into your theoretical knowledge. What you will have to do is look at the person and describe his mental state.

So don't worry about okay, this is the word I know whether it is fitting into that, sometimes things will not fit. So what is the subject versus objective mood.

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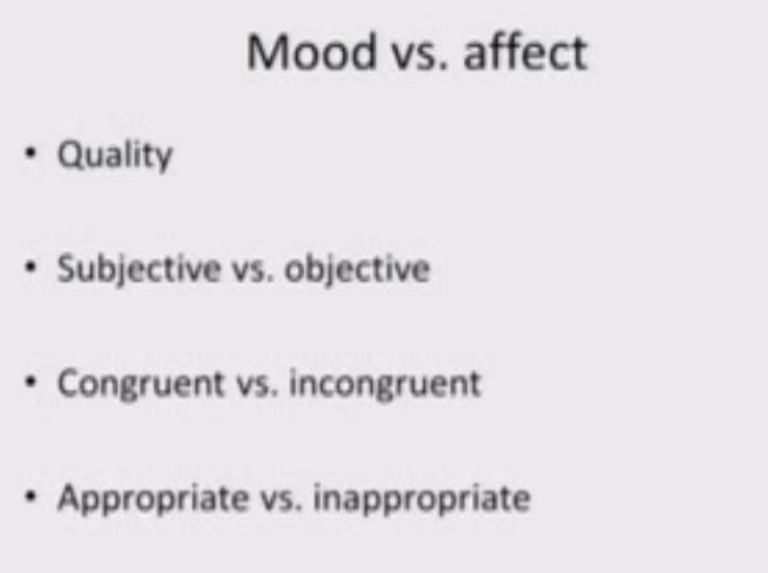

The person may say he is happy a lot of people when they are sad, and if you ask them why are you sad they will deny any nothing is there, I am fine. So you don't look at them and believe what they are saying, if they are saying they are happy that is the subjective report, objective report maybe that he is appearing sad.

We all know who is sad and who is happy, because if you remember from the previous module previous talk I told you about the mirror neurons. So a mirror neurons know.
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That this person is appearing sad, but he is saying I am happy now do not -- if he says do not immediately think that he is having some split of emotion and thought this you have to judge whether he is just denying it and if you continue talking with him don't decide on one half a second. If he continue talking his sad mood will appear.

Whether it is congruent versus incongruent the congruent versus incongruent means his mood is in keeping with his thoughts or it's not in keeping with his thought. If he is talking about somebody's death and he is giggling that is sudden incongruence between what he is saying and what he is feeling.

But a person is talking about say somebody is after my life and is expressing fear it is congruent, it is congruent between his inner state of thought and his mood, there is congruence. So congruence and incongruence is with the appropriateness within from within whereas if you say is appropriate versus inappropriate is in the external circumstances.

So if I am talking about some somebody's death and I am sad which is congruent if I'm talking about somebody's death and laughing it is incongruent. If normally most people when they lose something in a situation of sadness, if I am feeling sad along with thinking about this thing, then it is congruent. But appropriateness is with the external environment.

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Suppose if I am standing somewhere where somebody is died and I am laughing that is inappropriate. I am supposed that our mind has trained over millions of years to, as I use the word again and again context our mind has trained us to behave in a certain way in a context. And that is universality and commonality of training, all cultures laughing is

laughing, crying is crying, death people cry. So that is appropriateness somebody is behaving inappropriately then that is inappropriate mood. So moods generally has to be assessed on these things.

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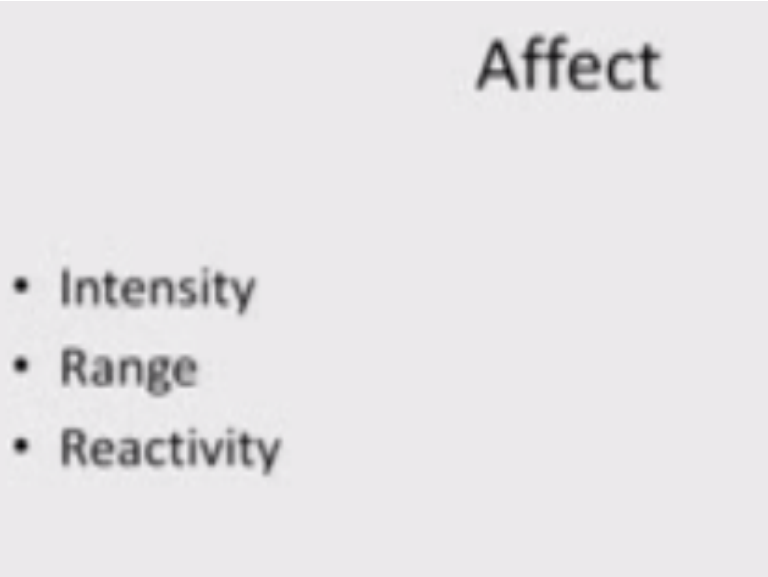

Affect is then and there what is the intensity, somebody may be extremely sad or extremely happy, extremely angry, whether that is appropriate or not we have to check that. What is the range whether within a conversation is the general conversation if you're not focus on one issue people shows range of behavior from happiness to sadness to irritability to mood so on so far reactivity.

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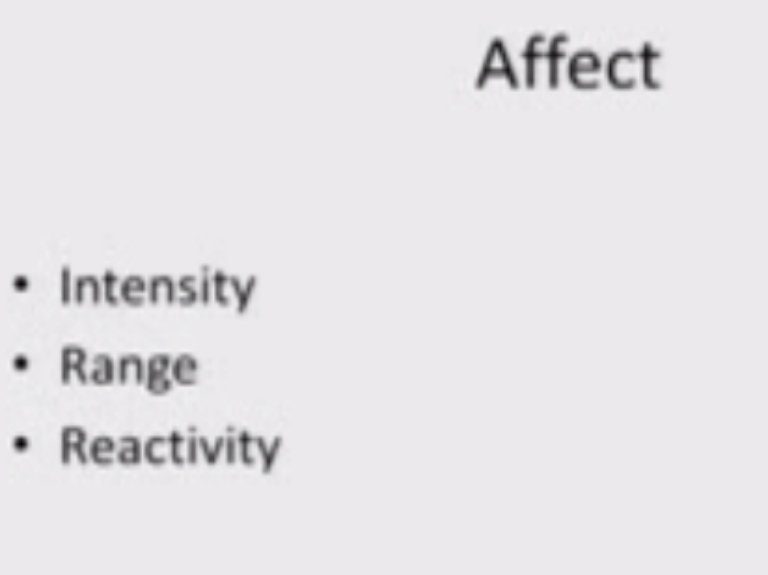

So that is a range we show reactivity is that when you say something whether the other person is showing appropriate reaction at all or not, you may suddenly tell a joke and the person will keep sitting flat. So either the joke has fallen flat or the person is not reacting, or if this -- so you have to not only keep talking about the patient's problem you have to talk about other things also to evoke some reactivity from the person.

So if you evoke reactivity then the normal range also gets exhibited. So you have to see whether the person is lack in depression people will react less, because they are so absorbed in their thought like a personal with obsessive compulsive disorder may not be, it's just worried about his obsessions.

A person with schizophrenia may not be listening to you and he may be actually losing his word and hallucinations, so he will not show the normal reactivity and range. All these things will indicate whether that person is actually in touch with you has all though even looking at you, if he has build a repo then he would show a normal range and reaction appropriate mood, congruent mood.

So which are the signs of normalcy normal people react to normal, abnormal things to joke and ought to a sad news, ought to worry some news, and they exhibit a normal

range, intensity obviously. So mood is like in the euthymic which is okay a normal mood, angry, euphoric, present may be extremely happy.

Hypothetic maybe and may just not be interested in what you are dysphoric may not lacking is exactly on the spectrum of dysphoria to total sadness.

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He maybe just not liking what you are saying or apprehensive very, very fearful or suspicious of the thing, there is another word which I should mention here called illation. There is a difference between happiness is a subjective state somebody may say, I am happy fine.

Euphoria is slightly more than that which is slightly more happy which is a sign of hypomania mania as illation. Illation is – it is infectious happiness that the person is happy and laughing or just happy and it is so infectious that you will whether you want you don't want you will -- that's what comedians do.

You know, but that comedians do not do, because they are acting is not that they are elected they can create illation or a song may put you in illation then illation is one of the

phenomena which often happens and dances and all. And people are dancing the music puts you into certain related mood.

And that illation does not restrict itself to the minute that would goes into the body and everybody starts, that is what the – why it is not abnormal that dance illation in a situation is not why, because of the context. So in a marriage where people are dancing on the beat of the drums that is normal, because the context is like that what is -- that person will suddenly sitting in a classroom and suddenly starts dancing and five – he is so illated and five other students start dancing.

So maybe that one who is having a illness and rest of them got a infectious illation right. So next important thing and see all these things are inter to and do not think they are that behavior in my look, and my rapport, my reactivity, my range and my mood all is separate from my thought.

They all link that is how the brain connectivity goes on within the brain, and even though maybe it is modular and parallel processing, but it still keeps a sense of unity. So what do you look in the thought.

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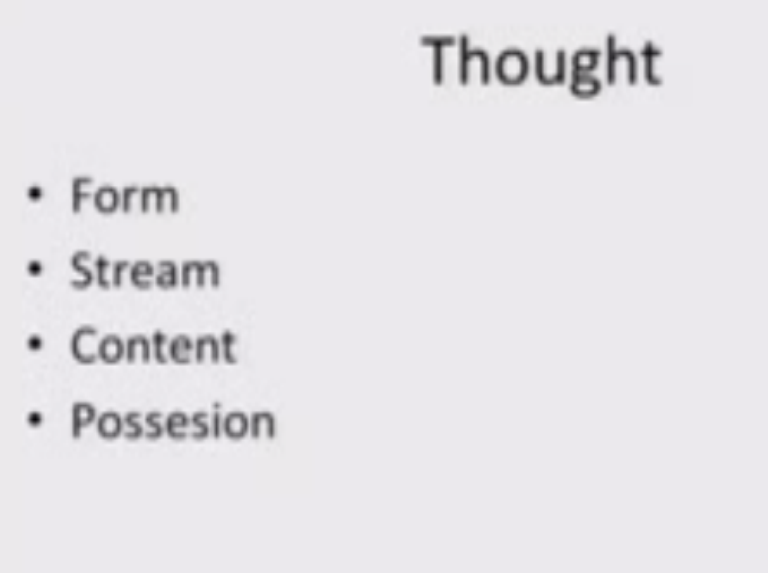

You look into a thought form normally when we are talking our one thought has a connection to the other thought, and to the third and the fourth. And that is how we make coherent logical conversations, monologue dialogue that is called the form of the thought, but there may be a disturbance in the form.

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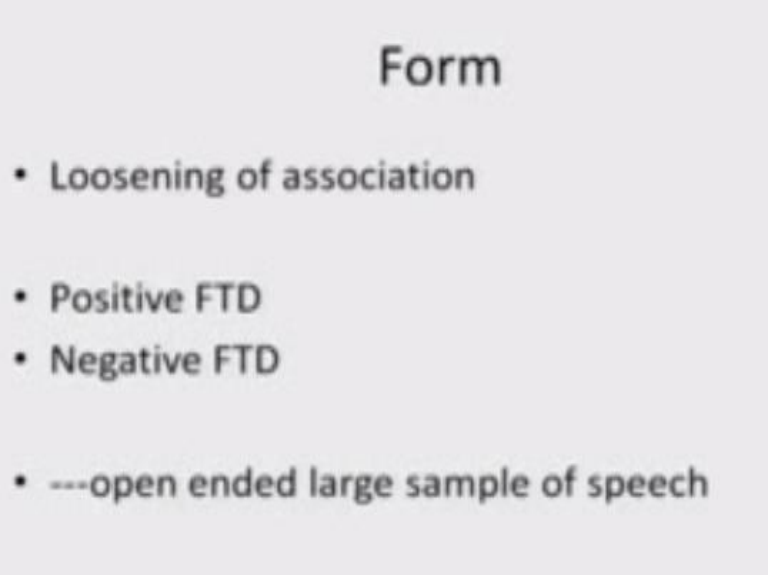

That my one thought may not willing to the other that it or it may be just linked some of them may be linked, some of them may not building, some of them have, maybe talking something other than suddenly I move on to something else, that is called loosening of association. In our extreme cases it can be what we call a formal thought disorder which is a hallmark of schizophrenia.

Formal thought disorder can be a positive formal thought disorder where in between this losing some new concept comes up or a negative formal thought disorder where there is the whole poverty of content, that the person may be talking for very long in an open-ended question or in and answer to the open-ended question.

But nothing emerges out of it, there will be no content what we call inane and thing in a normal conversation maybe our negative formal thought disorder. And the second thing we will look at it, but it cannot be just with the open and closed ended question how do you feel you will say I feel good, that you cannot decide on this.

Because formal thought is obviously are looking at the form and the coherent, coherence of the thought process. So you have to have a large sample of speech for which you need some open-ended questions and with a person can talk at length. So you look at the stream.

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The form is how the whole thought process is structured and stream is the flow not in the skeleton sense right in the sense of function. So what you will look the person may have circumstantialities if you ask some question for example what is your plan for today. Now the person may take an very torturous route to these that point, even if they start talking okay, I have a plan for today, but you know yesterday when I was there and day before yesterday somebody came to my house, he told me whether I will meet him day after tomorrow and I said yes I called him yesterday.

And he will reach the end, but he will take a very torturous route which may actually bore you. Tangentiality is different, tangentiality is that person maybe talking suddenly okay, I have a plan and today and I need to go to United States after six months, and is that totally from plan he must have taken of a tangential route.
It is easy to understand thought block is again a sign of schizophrenia where a person is thinking and for few seconds there is a total block, the mind goes blank it is one of the pathognomonic science of schizophrenia. And when the thought resumes it is a new thought all together.

Now if a person suddenly the mind goes blank it can go blank because of the anxiety, but person will pick up the thought link from the previous thought. So if I get a thought block suddenly I can't think for a second, but I still regain that previous thought it will not be thought block.

Thought block is like your mind suddenly goes blank, it is extreme anxiety provoking and you start from the fresh thought.

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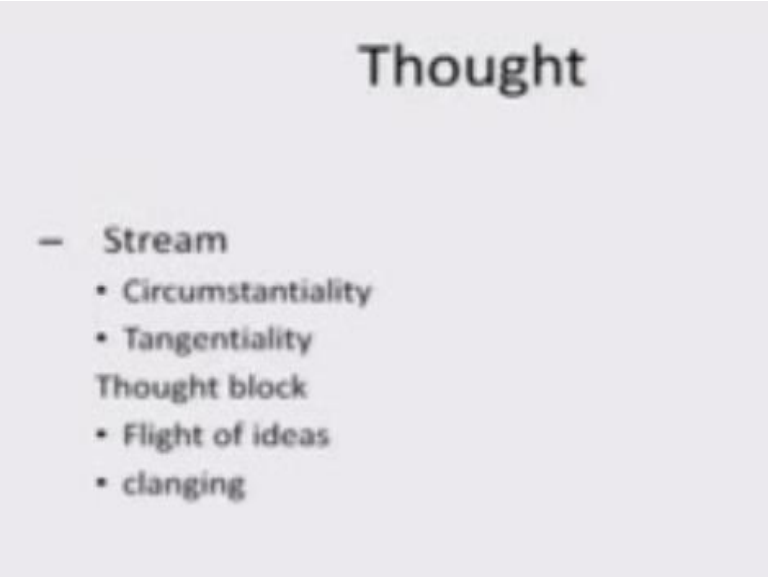

Flight of ideas is the hallmark of mania they can take off from anything, any sound they can link when one sound to another and go to another thought and just take off to another world all together.

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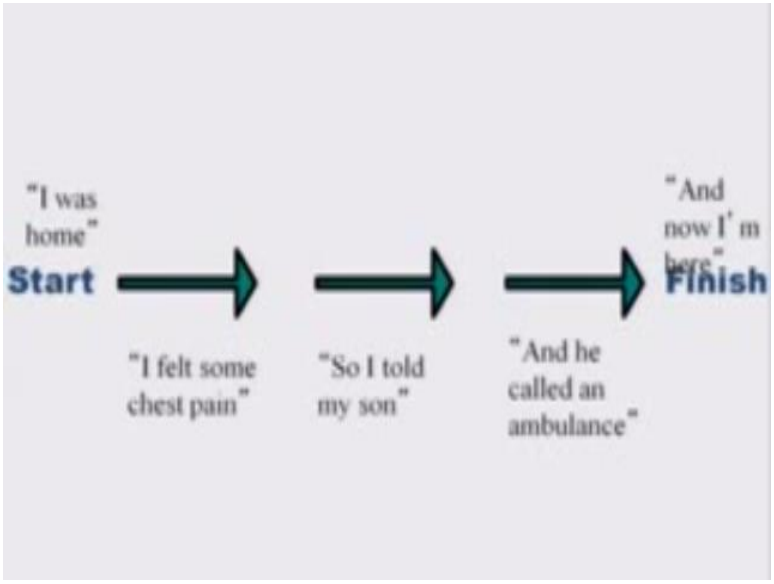

If you can look at this, I was home, and now I am here. I felt some chest pain, so I told my son and he called an ambulance and now I am here, this is normal okay.

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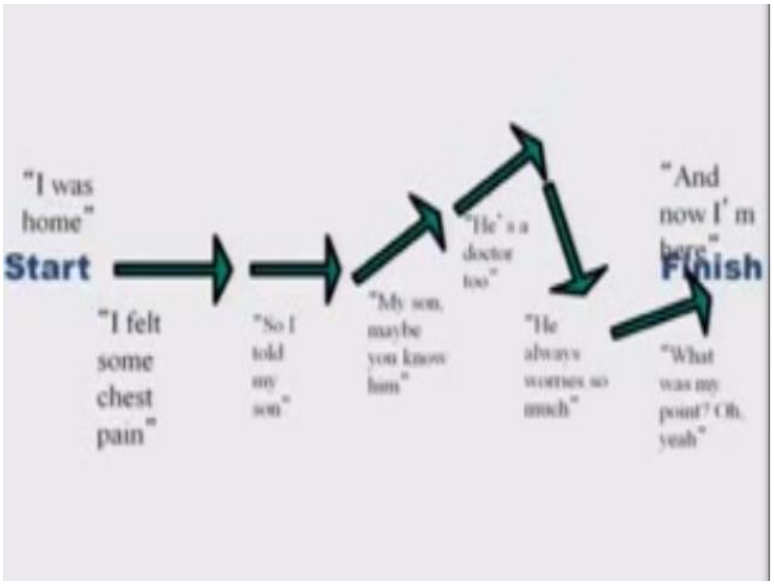

I was home, I felt some chest pain, so I told my son, my son maybe would know him, he is a doctor too, he always worries so much finish, what was my point, oh, yeah he has gone to different trajectory.

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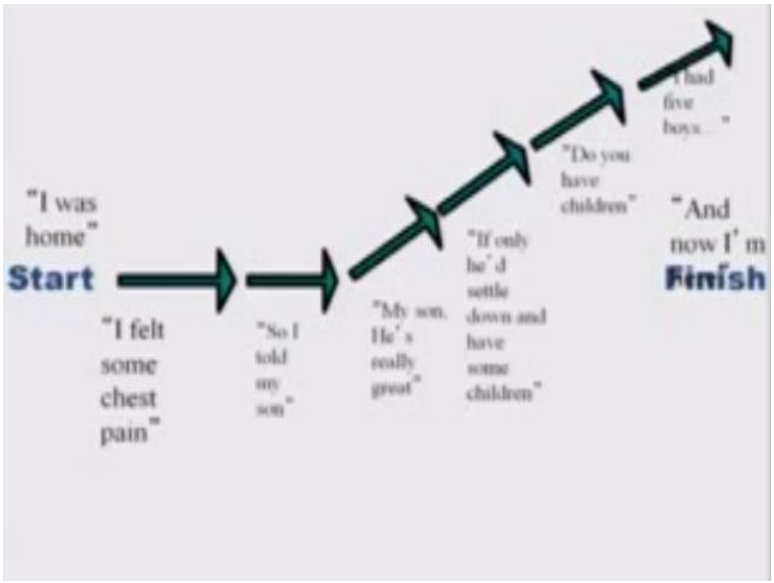

I was home, I felt some chest pain, so I told my son, my son is really great. If only he had settle down and have some children, do you have children so this tangentiality. He has just come here gone to tangentiality whereas the previous one was, if you look at it

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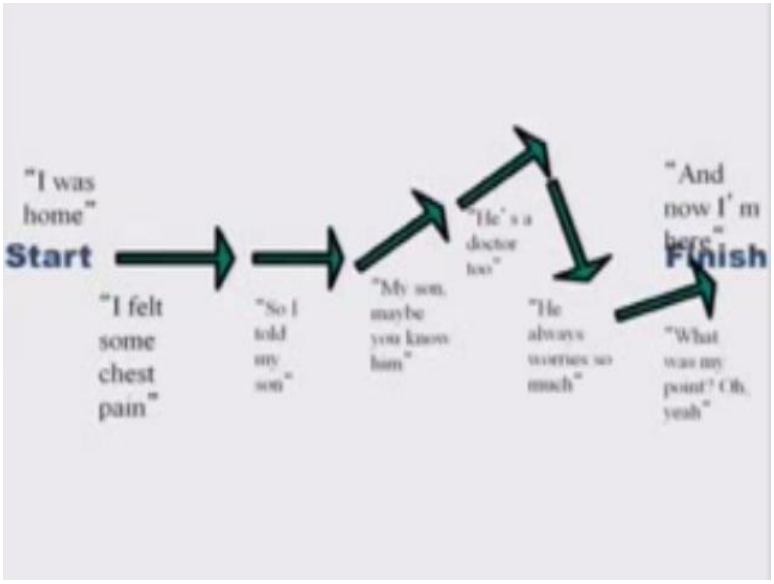

Circumstantiality, it will go around the route, come back here.

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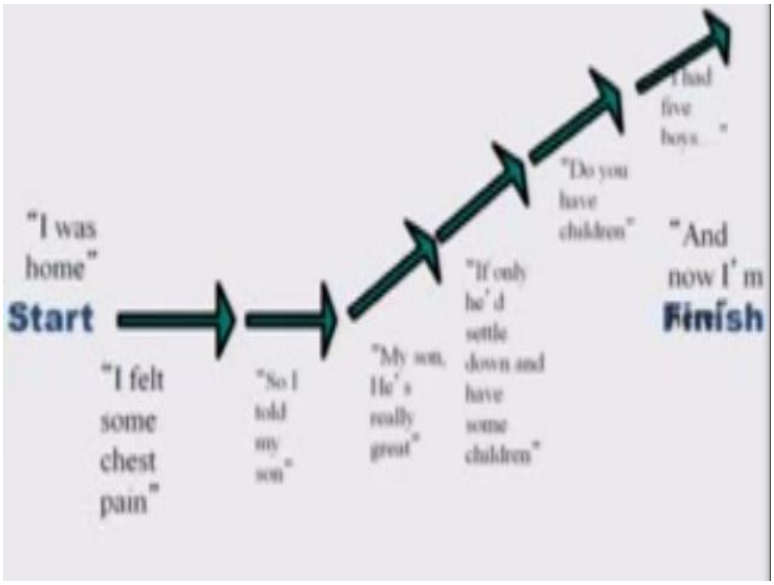

This was tangential okay.

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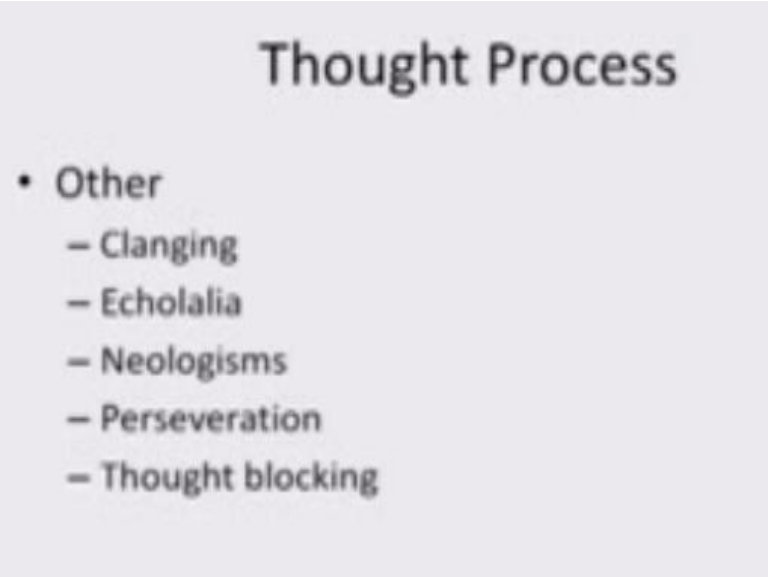

So other things were echolalia like they repeat the last word which is most fun and autism and other illnesses. Neologisms new words either all words are used in new context which is not usual for people or new words all together. Now Shakespeare introduce some 100s of new words which we can call neologism, but obviously created the context of it.

Perseveration is that when -- even if the question is shifted people keep responding the same thing it is a sign of frontal lobe damage that when you ask something, you ask something okay, what did you eat? He will say bread where did you eat? He will say bread, when did you eat? Bread.

So this word this is called perseveration, sometimes the ideas can persevere here. The same idea keeps on thought blocking as I have already told you.

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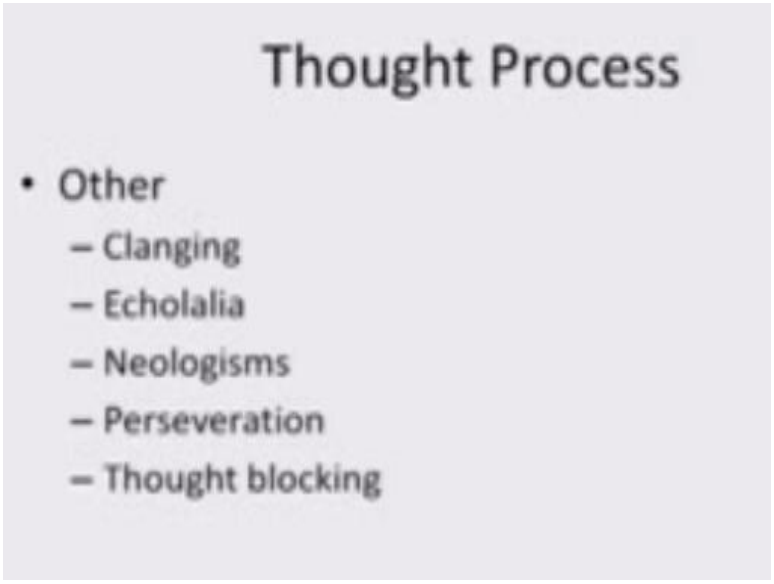

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Content, the content of the thought can be overvalued ideas that somebody believes that it is very different fine line between overvalued ideas and delusions. But delusions by definition overvalued to ideas people take one or two ideas in their lifetime and give their whole energy to it.

And it is not a question of right, wrong, good, bad, belief, it may have some routing and reality, but that idea takes over most of their life and ideas whereas delusion is a false fixed belief arising from one's own mind, and which has a morbid bases. Now the morbid bases, I can just clear you to by example on what basis that person is believing that itself is implausible.

Not impossible, implausible, an implausibility morbidity can be defined, let me give an example, somebody believes that my spouse is having an affair, but this is pretty possible somebody's spouse maybe having an affair. But if you ask this person how do you believe they will have without any concrete proof they will have a belief even if there is a concrete proof that somebody may be really having an affair, the basis on which they believe is morbid and the implausible.
Now what is that that, that is that is I know my wife or husband is having an affair, because when they come home and I'm sitting on a dining table they are putting the knife pointing at me, that this is like the morbidity of it. What you believe, because I believe when I lie down on the bed this person always faces the other side, it may have some truth.

But on these bases nobody can reach such a conclusion or some people believe that okay government of India is after me. Now this type of delusions are still into practicality the difficult to decide what is happening and listening now the full truth. But for somebody that they can be a bizarre delusion like somebody say government of India is spying on me how?

I know they have put a tower on to the other side of the road from which they are recording me and I know it, and you ask them the proof they will say no, no I just know

it. Now that is a bizarre delusion unlikely, is unlikely that president of United States of America has put in drones to kill me, depends on who is saying.

If I had a nation is saying from somewhere North Korea then you may be, but if somehow villager is saying this it is impossible. So delusion cannot be decided just on what they are saying it has to be decided on the whole context and knowing the rest of the history and background and that is why all that information, demography, and education and everything becomes very important in the background.

Position of the thought is like what is the thought process is what is it possessed by, it is possessed by repetition like an obsession, obsession is by perseveration is another position.

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As I said possessed by their simple answer again and again or an idea. Obsessions are repetitive thoughts from your own head which our ego dystonic, that they are not in your scheme of things which are anxiety provoking any attempt to stop them creates anxiety, they can win the form of a doubt like people wash their hands and their mind tells they

are do not washed or impulse suddenly there is every time somebody feel that every time I go to a height I should jump, or I should stamp somebody, or I should touch somebody.

Doubts, counting people some people keep counting unless the number plate till they reach a certain number. The act which people do a motor actor called compulsion if your mind keeps telling your hands are not washed, you have to keep washing it again and again, checking the door whether it's locked, if you are -- some people have, when you're walking you would take two steps forward, three steps unless they do it their mind will not be at peace.

Magical thinking if this is a hallmark of illness called OCD which is very, very becoming very malignant these days. Magical thinking is your mind keeps telling that if you do not do certain things in a certain way then something wrong will happen. So they have to keep performing things there is something called obsessive slowness which is a need for symmetry like five things are kept on a table they have to keep arranging it in the symmetry.

If there is something called ambivalence their mind keeps telling you will have to act this way or this way, this way or this way. Perseveration as I again told you, so these are -- by this phenomenon you can immediately diagnose. If somebody comes and tells you that this is happening and then you just have to take the demographic is through receive, since when it is happening and drew.

But you have to do a full examination which you get trained with time, but to know whether it is coexisting with some other illness and so suppose somebody tells you that my mind keeps telling me things again and again and you say its opposition okay, fine OCD.

It is not the right way, because you will also check whether the person is having along with the depression or existing of psychotic symptoms or, because psychotic symptoms by definition are hallmark of psychotic illnesses, which means that mind is out of touch

with reality. There is a lack of insight and there is a presence of delusion or hallucinations.

So one has to rule out the other things you just cannot take one phenomena and make a diagnosis on that otherwise it will be a huge error of judgment and treatment. Perception is like sensation is which goes through all of our senses and perception is the interpretation of that.

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Hallucination and illusion, illusion is when the stimulus is present and you misinterpret it like for example, you are going in a dark typical example and there is a rope and you suddenly take it as a snake and get for that is a illusion. There is a rope which your mind misperceived as illusion.

Hallucination is perceiving a stimulus when there is no source there, and a stimulus is not there like you are hearing voices when there is no voice around, nobody is speaking, there is no audio, no loudspeaker bulling away, no train passing and still you hear somebody talking to you.

So what you have to check if this is there you have to check the mortality in which mortality it is visual or auditory or touch or smell or content. What is the content and how much emotional disturbance it is causing. A content is like second person maybe somebody is talking to this person and saying why are you doing this, indirect second person.

Or there may be third person two, three people may be discussing about that person that there is another type of hallucination called functional hallucination the original sound is there, but that also -- that as long as the original sound is going there is another sound which is going on out of what is going on in the head that is functional like a water tap is there and the water is flowing over here, he is hearing was is that along the water is flowing.

The reflex hallucination that like if you see something suddenly you hear a voice, so a stimulus in one modality can trigger a stimulus in another modality. Synesthesia is when you feel or when you perceive in a modality which you are not supposed to, like if you see a rose you can still smell it that is normal.

But if you taste the rose or some people like here the color or see the sound that the synesthesia, as cenesthopathic is you are not supposed to know at all like your stomach absorbing food you are not supposed to, you are brain does not register that you're brain gets a feedback whether it is digesting or not, but it does not register.

So these hallucinations are all that the internal think this is the discrepancy between what you see externally the external input versus the internal imagery which is being created all the time. Now this internally which is normally suppressed by the conscious brain, so that you already get in touch with the reality, but sometime this internal images overpower what is being sent from the outside.

And then if they are so strong that they create emotional reaction then one tends to believe this and one tends to respond to this internally imagery is other than going on to

the external imagery and that is the hallmark of psychosis. So false fixed belief delusion and hallucination is a hallmark of psychosis, but not all psychosis people were not be disorganized they may continue with their life and still be having delusions.

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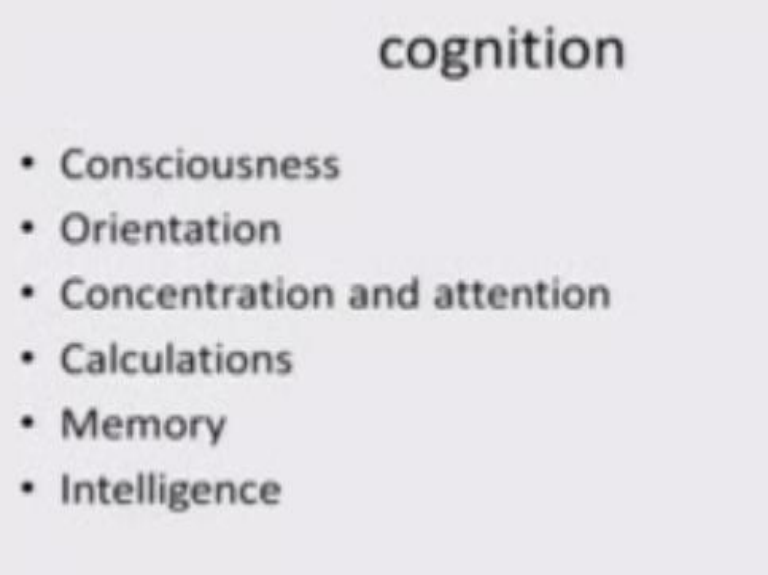

So the last part is cognition which you will know why they are talking to the person, whether the person is conscious, oriented to time place person, because these are two signs of neurological illnesses. Whether the person is able to concentrate and attend to what you are saying, because inorganic illnesses or illnesses like dementia and other saying withdrawal lot of these things which are baseline for living.

Being oriented to time place person, being conscious, not consciousness in the sense of philosophical debate. But being conscious is being conscious of where you are and orientation and concentration and attention.

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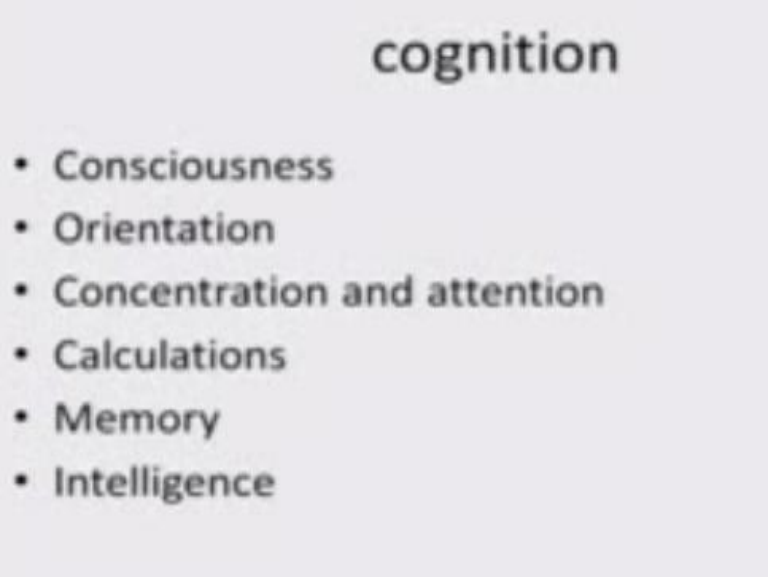

Attention you can check you can ask, give three or seven set of three numbers or three words and ask them to repeat it after you. So if they are paying attention they can repeat it to or may 100-7 go down serially if the person is paying attention they will be able to tell you calculations memory you have to check immediate recent and long-term memory.

Long-term memory is obviously the personal declarative memory, the address, and short-term memory you give them some words, some objects. Objects for the visual memory words for the verbal memory and ask them after five minutes. So if the short-term memory is intact the mind would have seen it caption in the mind and keep revising it.

So that they are able to recall, immediate is you asked tell your name and ask immediately, so if the person is not paying attention immediate memory it is very hard to exist, and short-term memory losses all the signs of dementia as we know.

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Inside these patients capacity to acknowledge to appreciate illness associated implications and consequences. So people vary from absent inside to pull inside normally a normal person one sign is full inside. Now at times when you are talking to people you may just that the person doesn't have an insight into what he is saying.

That it can may be planning some high flying career without putting into the right word, but if you probe deeply the person would know the person would know I have sent inside the sign of psychosis.

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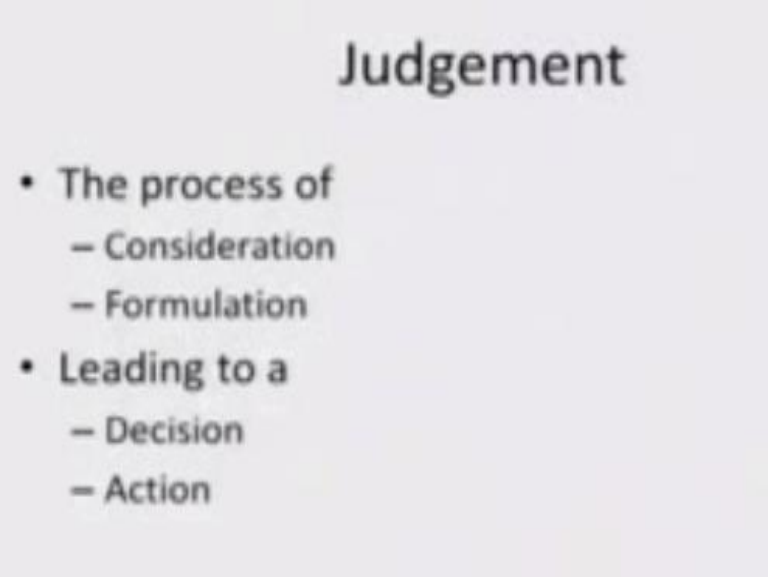

So and judgment you give him a situation and see what the person decide there were person is on fire what will you do, or if we get a swollen these ordinary things where normal people will do normal actions can give you idea to the judgment.

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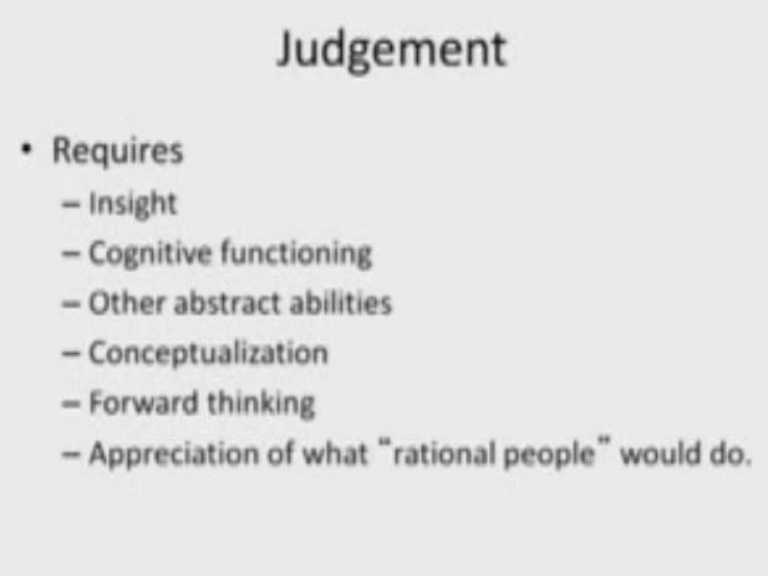

So judgment requires inside cognitive functioning, other abstract ability, conceptualization. Abstraction is where you check whether people can generalize from things; they just ask differences and similarities between, say proverbs or objects. So differences people can tell similarly for similarities you need generalization that conceptual thinking whether it is there or not.

So this is broadly an overview of how you do the mental status examination lot of it is may appear as common sense, but some phenomena are specific. All of us apart from the psychotic part of it about from the delusion, illusion and lack of inside. So far there is a range and reactivity and know what.

But normally people when they are not ill suffer mood changes for brief periods and they bounce back brain bounces back to normality. Even a small thought there are elements here and there are normal for most people, but they are all temporary lasting for hours to maybe a day, some of the illnesses can also last for a day.

But cross disturbances, more sustained episodic continuous they are the indicators of illness, but illness, psychiatry illness cannot be decided on just one phenomena the period of that phenomena, the intensity of the phenomena plus associated phenomena in keeping with the context and background of the person will give the real indicator whether the person is ill or not.

So I guess that gives you a broad idea about how we look at illnesses and the next lecture we will talk about how we have gone on to classifying the psychiatry illnesses and some of them the hallmarks of that which will give you a more idea about what is happening. Thank you.