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The Role of the Question in Psychiatric Medical Diagnosis

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Medical and psychiatric diagnosis represents a species of diagnostic thinking by means of which a problem is solved or a stage in solving a problem is achieved. Thus, a doctor who formulated a correct diagnosis solves a problem by answering a series of questions ('Is person x ill?'; 'Which disease does he or she suffer from?', etc.). In addition, to diagnose a case represents a stage in solving a more general problem situation, that, in its turn, can be formulated as a question: 'What must be done for the person x, who is ill, not to suffer any longer?' (Ionescu, 1985). A subject who can understand a problem situation and is engaged in solving it, must answer the questions.

Problem situations can be divided into practical and theoretical ones. Thus, for philosophers, the problem situation can be described by questions such as: 'What is the nature of human beings?' or 'What is knowledge?'. Surely, such questions are not formulated directly to philosophers by another person under given circumstances, but they ask them of themselves in the name of the tradition of philosophizing. For scientific researchers the questions result from unsolved aspects of the respective science, translated and formulated in the terms of concrete problem situations (Grecu, 1982).

Practical problem situations, in their turn, can be divided into those that occur spontaneously in people's daily lives and those that are solved in certain institutional frameworks (juridical, medical, etc.). Under all these circumstances subjects who understand the problem exhibit diagnostic thinking by which they answer some questions, formulating a certain diagnosis which stands at the basis of future practical actions. We can mention:

- criminological diagnosis, answering the question: 'Who commited crime x?';
- juridical diagnosis: 'Is or isn't person x guilty of y?';
- typological and characteriological diagnosis: 'What is the intelligence level, what character features has person x?', 'Do all these allow him to hold function y?';
- diagnosis that identifies and estimates a political situation;
- diagnosis that identifies and evaluates a work of art, etc.

In all these cases the intellectual process of diagnostic thinking extends between two limits: accurate identification of a given reality depending on certain criteria and classifications on the one hand, and an estimation of a given reality (of a 'case') depending on certain norms and values, on the other hand.

1. Diagnosis formulated within a certain institutional framework, as is the case with medical diagnosis, is usually determined by professional specialized persons. Usually such specialists engage themselves in solving problem situations as a result of 'request questions' that are put explicitly to them. The patient comes to the doctor and asks:

'What disease do I have?', 'What must I do in order to recover?'. But 'request questions' may not be verbal. For example, if in the emergency room somebody is brought in with coma and fractures the doctor begins to develop the process of diagnostic thinking without being asked for it. During this process he or she may ask himself or herself questions like: 'Which disease does the patient suffer from?', 'What examinations must I do in order to clarify the diagnosis?'. Further on in this article, the problem of diagnosis in medicine in general and in psychiatry in particular will be discussed in detail, emphasizing the way in which questions occur during this process.

2. Thinking that leads the doctor to the formulation of a diagnosis develops according to the general scheme of any action, described by Flammer (1989) as follows:

- The person prefigures a present action process;
- He or she adopts a plan that is to be developed in order to achieve an aim;
- The person tries to obtain a series of information both from memory and from other sources;
- For obtaining some necessary information he or she asks other persons, too.

Flammer systematizes the possible information as follows:

- information from perception of concrete surrounding reality;
- 'symbolic' information to which the subject has access: books, signs, notes, paintings, computerized cards, etc.;
- data concerning memory, data previously acquired by the subject;
- data given by another person spontaneously or from being asked.

Flammer's scheme permits us to delimit the main directions of the question formulated by a doctor during the process of diagnostic thinking. These are:

2.1 Questions to himself or herself: they are correlated with the action process, with the preparation of some questions to outside sources.

2.2 Questions to other persons: these are addressed to the patient and his or her group (relatives, friends, etc.).

2.3 'Factual informational' questions: these are addressed to the body and behaviour of the patient and to the possible 'symbolic' information; the answer consists of information that is not related orally by the patient or his or her group.

3. In order to trigger a diagnostic process, the doctor is asked by the patient and his or her group. This 'solicitation question' has a nonverbal part, too. The bad condition of health represents a 'question solicitation'. However, the main questions to the doctor are formulated orally, more explicitly or more implicitly by the patient or his or her group. These are:

3.1 Is person x ill or healthy (normal or abnormal)?

3.2 If person x is ill, what is the disease?

3.3 What is the seriousness of the disease that person x suffers from?

3.4 What are the possibilities of treatment and recovery in general, possibilities that influence the reactive disease or abnormality?

3.5 Which would be the best accessible means of therapy (recovery) in case x? Which alternative formulas exist? What are the risks of the therapy? How long do they last? How much does the therapy cost?

3.6 What could the patient (and his or her group) expect in the near and remote future when a given therapy is applied (What is the prognosis)?

3.7 What are the patient's capacities (effort, work, etc.) in the present moment of illness, and what will be the expectations?

3.8 Others.

4. All the forementioned questions are included in the diagnostic thinking process. On the basis of the initial information regarding the patient (resulting from his or her solicitation, first accounts, the first observations on body condition) the doctor formulates a series of diagnostic hypotheses. He or she appeals to his or her memory, knowledge about symptoms, syndromes and diseases, the nosologico-nosographic system (within the framework of which there are explicit specific definitions for all these). He or she also appeals to his or her own experience, to similar cases formerly diagnosed and treated. Developing a process of thinking that presumes logical operations, the doctor describes by a tentative hypothesis a series of the probable diseases in the given case: If person x suffers from one of the y, z, etc. diseases, there must be present indexes $a,b, c \ldots n$ (as symptoms, syndromes, conditions, causes, etc.). From all these result the questions in 2.1, 'Which diseases are suggested by these indexes? What index shall I look into further? What does the new established index suggest?'.

In order to clarify the difficult situation of diagnosis, after the inner questions the doctor asks externally. He or she can ask other persons (2.2) or can ask some factual-informational questions (2.3).

Questions to other persons (2.2) are addressed to the patient and his or her group. They can be of different types: open, closed, direct, indirect, etc. (Dillon, 1984). For example, the doctor can ask: 'What's wrong with you? Do you have pain? Have you headaches? Where? How? When is the ache more severe? Is it accompanied by nausea?' etc. The doctor develops a strategy of questions being guided by the diagnostic hypothesis and the received answers. There is a succession: question-answer-question. In this case the doctor has the initiative, the patient's questions to the doctor being usually placed at the beginning or at the end.

The doctor can also formulate questions whose answers consist of established factual information (2.3). For example, he or she asks himself or herself as well as others if the osteo-tendinous reflexes are normal; he or she examines the patient, finds the answer. Or he or she asks himself or herself if the blood sugar content is normal; he or she draws off blood, does the analysis and gets the answer. Sometimes, such questions to which the answers are obtained by observation can be combined with verbal questions. For instance, the doctor may ask the patient if he or she feels a certain kind of pain while the doctor is pressing on a certain part of the patient's abdomen in a certain way. Besides the outside observational questions, getting the information from specialized books may be interpreted as answers to a question as well. In other words, the doctor may ask the books when he has some obscure points.

5. Further on we shall relate in detail the problem of verbal questions in medicine. It was mentioned that the beginning of questions formulated by the doctor requires a minimum of initial information that appears at the same time as the patient's solicitation-question, thus permitting the formulation of diagnostic hypotheses. In the first phase, the patient usually offers spontaneously to the doctor a series of information about his or her suffering. This information can appear as answers to the doctor's general questions such as: 'What's the matter?', 'Why did you come to see me?'.

It is known (Balint, 1972) that patients usually see doctors not only as a solicitation (diagnosis, therapy, help for their suffering) but also prepared to give them a series of important information from their points of view. This information contains only partly important data for diagnosis. They can ignore or minimize some experiences, their self-information and verbal utterance capacity can be low (owing to a low level of intellect, education, training). They can be influenced by preconceived ideas, by popular opinions on disease, etc. However, if doctors do not listen attentively to this informational offering, the patients will be frustrated (Enătescu, 1981). Doctors must start to ask

questions after having listened to a part of the spontaneous account of the patient and finally they must achieve a dialogue on their diagnostic hypotheses. Doctors' questions must be formulated clearly in order to be easily understood by patients. It is also important for doctors not to forget to ask some general questions (for example, questions concerning sleep, appetite) or special ones (concerning irradiation of pain, etc.). Medical education ought to offer students some sets of questions, as complete as possible, for the important syndromes. This would be very useful from a pedagogical point of view (Maguire *et al.* 1978).

In general, medicine has not given great importance to questions in contrast with other fields such as pedagogics. Patients' answers can sometimes be unclear, inaccurate, false. Patients can exaggerate the intensity of some symptoms or they can affirm as present nonexisting symptoms in order to simulate the existence of a disease, or they can deny some symptoms in order to dissimulate a disease (Deutsch and Murphy, 1955).

6. Questions addressed by doctors to patients' groups are based on trying to identify the existence of some symptoms. But doctors must also examine the onset and the evolution of the symptoms up to the present, and the possible causes of the disease. They must find, by means of questions, data concerning the patients' biography, character, recent stressful life events, the problems the patients are interested in, their present affective condition, attitudes towards the disease, wish for healing or death, etc. Thus, human doctors must understand patients not only as 'organisms in dysfunction', but must inquire about the identity of the patient's being, about the originality and unique qualities of his or her personality, in order to understand the patient as a sentient, spiritual, problematic being, in a special, dramatic moment of his or her life.

7. In psychiatry, the problems connected with diagnosis, and the importance of questions as part of this, are similar to medical diagnosis generally. But there appears a series of peculiarities, emphases, specifics that will be presented below (Kendell, 1975; Stevenson, 1968). We must emphasize the fact that, in psychiatry, most symptoms consist of subjective feelings. The doctor can have knowledge of them only by the patients' spontaneous confessions (more rare) or by question and answer (more frequent), or by 'psychiatric interview' (Sullivan, 1954; MacKinnon and Michels, 1971; Maguire, 1983; Ginsberg, 1986).

7.1 If in the general practice of medicine subjective feelings, as symptom, play quite a small part (being usually reduced to pains, unpleasant diffuse sensations, fatigue, nausea, giddiness), in psychiatry they represent the essential point of symptomatology (as: anxiety, panic, fatigue, sadness, obsession, exaggerated euphoria, hallucination, sensation of transparencey and psychic influence, delirious convictions, etc.). Surely, these subjective feelings are usually correlated with expressive symptoms and perceptible behaviours (Enătescu and Pamfil, 1977; Cox *et al.*, 1981). For example, if the doctor sees that the patient stands motionless he or she can think that the patient is absorbed by a delirious idea, or is struggling with an obsession, can hear hallucinating voices, is depressed, etc. In order to clarify the situation, the doctor must find out precisely which are the subjective, pathological feelings of the patient.

7.2 In very many cases of psychiatric disturbances, patients do not spontaneously tell their abnormal subjective feelings that represent the symptoms of their disease. If they are not asked (sometimes insistently), they do not inform doctors about them. For example, one patient hospitalized for schizophrenia with auditory hallucinations—hearing voices discussing him although nobody else was in the room—had been hospitalized in another psychiatric section a month before and discharged with the diagnosis of 'anxiety neurosis'. Asked if a month ago he had already been hearing the voices, the patient answered affirmatively but said he didn't tell any doctor this fact because nobody asked him about it.

7.3 In addition, psychic disease can also induce other pathological facts with the value of symptoms such as social withdrawal with great difficulties in achieving social contact and communication. The patient can be little interested in the presence of another person next to him or her, uninterested in this person's questions, without desire for communication. Sometimes this disturbance can be manifested by quantitative reduction of speaking, slowness of thinking and speaking, stubborn silence, etc. Sometimes he or she answers only after repeated inquiries with a short, telegraphic answer. Other times he or she does not answer at all. Later on, the patient can remember the episode declaring that he or she had the feelings but was unable to communicate with anyone.

7.4 Another psycho-pathological peculiarity is that the disease can modify the process of thinking and speaking of the patient. Thus, one may hear:

(a) 'half crazy answers', i.e. the patient answers the question immediately but the answer hasn't a direct connection with it. For example, 'How old are you?' Answer: 'It is raining', or 'The chair has four feet';
(b) absurd, illogical, vague, uncomprehending answers. For example, 'What is your name?' Answer: 'The name is a determinism of the human being that comes up from essential to individual but nowadays when the sun explodes, I run away and you are a pig'. The same for cases 7.1, 7.2, 7.3, where such answers become by themselves symptoms of psychic disease.

7.5 In some cases patients do not answer correctly because they do not understand the question owing to some cognitive disturbance (this happens for instance in cases of delirium or dementia). Patients answer with difficulty to the stimuli, without realizing their situation, or recognizing the interlocutor, nor understanding the meanings of words, etc. In spite of serious deficiencies in understanding, patients can sometimes give an immediate, improper, confabulated, answer.

7.6 Patients with psycho-pathological disturbances can present a spontaneous tendency to mendacity or confabulation, i.e., imaginative deformation (guided by preconscious tendencies) of information or to verbal imagination and affirmation of some events that have never existed. Thus, the pathological answer to the question is sometimes based on imagination, without any real support. In addition, we can mention the exaggerated tendency of some psychic patients to simulate or dissimulate (in the sense of a morbid emphasis on the mentioned facts). From what has been mentioned from 7.1 to 7.6 it follows that the questions and answers of a psychic patient must be continuously evaluated and interpreted. The way in which the patient answers (or the fact that he doesn't answer) constitutes a kind of answer, an intermediate index or a symptom between the content of the answer and the expressive behaviour of the patient.

8. In order to get a diagnostic formulation, the psychiatrist's thinking relies on the offered and obtained information, the diagnostic hypotheses and the questions to himself or herself as well as knowledge of the definition of symptoms and syndromes of the disease; these last belonging to a nosologico-nosographic system accepted by the doctor and the scientific community.

8.1 In order to find out by means of questions if a patient presents a certain symptom, the doctor must have in his or her mind an explicit definition of it that is agreed by others too. That is why manuals have been elaborated containing such definitions. Here is, for example, according to the PSE (Wing *et al.*, 1974) (see 9.3) the definition of verbal non-affective hallucinations (symptom 62 from this manual, p. 164):

62. Non-affective verbal hallucinations (about subject). This symptom includes only a voice or voices heard by the subject speaking about him and therefore referring to him in the third person. Consciousness is clear. The context is not depressive or

grandiose in keeping with the mood. (Exclude for example, 'This man is evil, we must hang him'). Include both true and pseudo-hallucinations.

How can the psychiatrist have information about the symptoms? Certainly, by asking the patient. The same manual recommends using the following interrogative strategy during the structured interview. At a certain moment the psychiatrist asks the patient (p. 210):

Do you hear several voices talking about you?
Do they refer to you as 'he' (she)?
(What do they say)?
(Do they seem to comment on what you are thinking, or reading, or doing?)

8.2 The symptoms can be variously combined within the framework of some syndromes that represent an assembly of symptoms, interconnected coherently and frequently met together. Here is, for example, the operational definition of generalized anxiety according to the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-III* 1980; p. 233):

Diagnostic criteria for generalized anxiety disorder
A Generalized, persistent anxiety is manifested by symptoms from three of the following four categories:

(1) *Motor tension*—Shakiness, jitteriness, jumpiness, trembling, tension, muscle aches, fatiguability, inability to relax, eyelid twitch, furrowed brow, strained face, fidgeting, restlessness, easy startle.
(2) *Autonomic hyperactivity*—sweating, heart pounding or racing, cold, clammy hands, dry mouth, dizziness, light-headedness, parestesias (tingling in hands or feet), upset stomach, hot or cold spells, frequent urination, diarrhoea, discomfort in the pit of the stomach, lump in the throat, flushing, pallor, high resting pulse and respiration rate.
(3) *Apprehensive expectation*—anxiety, worry, fear, rumination, and anticipation of misfortune to self or others.
(4) *Vigilance and scanning*—hyperattentiveness resulting in distractibility, difficulty in concentrating, insomnia, feeling 'on edge', impatience.

B The anxious mood has been continuous for at least one month.
C Not due to another mental disorder, such as a depressive disorder or schizophrenia.
D At least 18 years of age.

8.3 A psychic disease or a nosological category consists of a complex of common psycho-pathological syndromes together with a certain determinism. They appear more frequently given a certain background (genetic, typological, by sex and age); they have an evolutive tendency and react in a certain manner to certain therapies. The assembly of disease belonging to a certain speciality, for example psychic diseases, are connected in a certain way and they are systematized by specialists in a 'nosologico-nosographic system', within which various diseases have certain names and definitions and are placed in a certain order in certain chapters. There have been elaborated International Classifications of Diseases (ICD-9, WHO, 1977), according to which each of these is identified by a code. Sometimes a patient can present, at the same time, more diagnostic categories. There can also be presented disturbances that can hardly (or not at all) fit the diagnostic categories of a nosologic-nosographic system.

For research and progress of knowledge it is very useful to diagnose some 'pure' cases and that is why there were elaborated a series of Diagnostic Criteria for Research

(RDC). Of course, such a set of diagnostic criteria directs the interrogative attitude and techniques of the psychiatrist. A famous RDC was edited by R. L. Spitzer (Spitzer and Endicott, 1978). This has influenced the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III), edited by the American Psychiatric Association (1980). This manual proposes a diagnosis on five axes as follows:

Axis I—The present psycho-pathological aspect based on diagnostic categories limited by operational definitions and definitions of the terms comprised in an added glossary.

Axis II—Type of personality (normal or pathological) for adults and specific development anomalies for children.

Axis III—Concomitant somatic disorders that cause the psycho-pathological state or are simultaneous with or consequences of them.

Axis IV—Stressful life events identifiable in the last six months (with a gradation of these between 1 and 7).

Axis V—Social functioning level a year ago.

Obviously such a diagnosis based on axes doesn't amount to a diagnostic category of the classical nosologico-nosographic systems. But it can direct the strategy of the psychiatric interview. Even more, there can be elaborated and used structured interviews regarding the whole system of DSM-III (Spitzer and Williams, 1983) or for one of these axes, for example, axis II (Pfohl *et al.*, 1982).

9. The first problem of the psychiatrist who diagnoses consists in establishing 'the clinical feature of the present state' (axis I in DSM-III). This consists especially of abnormal subjective feelings. Information about these can be obtained from the patient by spontaneous confessions that patients consider to be important for the doctor and especially from patient's replies to the doctor's questions. So, it is an interview. It gives rise to several methodological problems.

9.1 A special problem refers to the period of time during which the feelings-symptom must have been present so as to be considered significant. The PSE system (Wing *et al.*, 1974) establishes in an arbitrary way 'the last month'. There are diagnostic systems that specify other time periods, such as 'last week' (Ansberg, 1978), or 'the last six months'. Many times it is difficult to establish at the first interview for how long the feeling symptom has been present; the problem will be cleared up at subsequent interviews.

9.2 In order to accomplish an efficient and useful interview, the psychiatrist knows and has permanently in his or her mind the inventory of all symptoms, syndromes and diseases that can be present in the case of a given patient. Surely, many times, it is obvious that a series of symptoms (syndromes) are not present in a given patient. Many clinical specialists come to the conclusion that the doctor must have in front of him or her, on the occasion of each patient's interview, a finite list of symptoms (syndromes) that could be present and that the presence or absence of them must be mentioned explicitly, not forgetting certain symptoms (syndromes) that could still be present. This system is proposed by the AMDP (1981) that has been functioning for over twenty years in Europe.

9.3 Psychiatric diagnostic experience has led to the conclusion that, at least within the framework of the researches made in different parts of the world— and for the general progress of psychiatric science and practice—it is necessary not only to take into account all the above mentioned things but also to use accurate, completely formulated questions. This is the principle of some 'structured interviews' elaborated for research, as that elaborated by Iowa University (Tsuang and Woohom, 1978). In this system, for example, in order to establish whether a patient has auditory hallucinations, the following question is to be asked:

'107 Did you hear voices when there was nobody about, voices that seemed to come from outside?'

Sometimes in structured interviews more questions are allowed, which are also specified. This is the principle of the PSE system (Wing *et al.*, 1974), from which was presented the example from 8.2. On the basis of this PSE structured interview have been conducted the main WHO studies concerning schizophrenia and affective disorders. Within the framework CATEGO (that can be used by means of computer) there is a finite list of symptoms, presented and enumerated in a certain order. Each of these has an explicit definition (clear and unequivocal) and a clear formulated question (sometimes with several variants that are also presented in the text). The investigator has to question the patient asking exactly the questions from the manual in the specified order. The 140 symptoms are grouped in thirty-eight syndromes. If it is obvious that a group of symptoms is not present, the remaining questions from the groups can be given up passing to the next indicated chapter (specified in the manual). The investigator must have personal experience with psychiatric interviews and PSE applications; he or she must be convinced that the patients have understood the question well—that they aren't influenced by the investigator and that they are not asking at random; therefore they are sometimes asked to offer examples, etc. The investigator must estimate the intensity of the related symptoms in three degrees of intensity.

In the interview scheme of PSE there are four types of questions:

(a) compulsory questions (fifty-four in all) used in the case of an interview with general character;
(b) auxiliary questions that help to diagnose the nature and extension of a symptom; which must be used if there is any doubt with regard to the answers to compulsory questions;
(c) questions used after having cleared up the compulsory questions;
(d) questions that help to clarify those from (c).

The PSE system has been translated into many languages. One of the most difficult problems of the structured interview of the PSE type consists in translation fidelity of questions in various languages. Sartorious (1979) recommends verification by successive translations from one language into others and by retranslation.

9.4 The PSE system represents the prototype of the structured psychiatric interview, relatively rigid but assuring good replication by different investigations in different languages. There have been elaborated concomitantly and successively other structured interviews (Spitzer and Endicott, 1978; Tsuang and Woohom, 1978). Another type of interview or questionnaire tries to identify certain psycho-pathological features or dimensions present with a patient; for example, Cattel's 16 PF (Cattel and Butcher, 1968), the MMPI (Hathaway and McKinley, 1951), which consist of written questions. The subject answering them can be distinguished by certain psycho-pathological tendencies with different degrees of intensity. There have been also elaborated semi-structured interviews in which are given the list and order of investigated symptoms without requiring the exact formulation of a standard question, the investigator having more freedom in question formulation.

No matter how elaborated they are, structured and semi-structured interviews are in principle limited. They do not claim to be exhaustive regarding the inventory of all symptoms (subjective and expressive-behavioural). On the contrary, they are restrictive, trying to reduce the number of symptoms and syndromes to an essential minimum. What is gained in standardization (in convergency and certainty of the diagnosis) is lost in

variety. That is why structured interviews do not substitute for traditional psychiatric examination and other investigating methods.

10.1 In view of a shaded and discriminating analysis of a certain domain of pathology can be elaborated structured interviews, aiming to refer merely to a field of psycho-pathological problems, deliberately ignoring other fields, unconnected with the given case. For example, in order to clarify the anxious-phobic and obsessive pathology, the interview ADIS has been elaborated (DiNardo *et al.*, 1985). Such interviews have been elaborated aiming at other fields of pathology too, such as somatiform disorders, mania, depression etc.

10.2 In the elaboration of a medical diagnosis in general and of a medico-psychiatric one especially, of great importance is not only the present symptomatico-syndromatic frame, but other parameters too, such as: characteristics of basic personality; history of life (including genetic features, demographic data, important stressful life events); functioning level (social adaptation) before disease onset; determinant somatic pathology of the present state, consecutively or simultaneously with the disease state, etc. Structured or semi-structured interviews can be elaborated for all these aspects, for example a scale to measure the stress of life events (Zimmerman, 1982), elaborated for these aspects as well.

The evaluation of presence and intensity of some psycho-pathological symptoms that are present at a certain moment is also important for the appreciation of their changing in time, during the applied therapies. If we have a depressed patient, we can apply and repeat at regular periods of time: ample psycho-pathological scales consisting of structured interviews that comprise more psycho-pathological symptoms and syndromes, such as the CRSP (Ansberg, 1978); scales focused on depression that take into consideration a number of items, symptoms which the investigator must evaluate as presence and intensity, by questions and observations—as, for example, Hamilton's scale (Hamilton, 1960), with twenty-five items, giving a score to each of these (between 0 and 3) and getting a general final score at the end; self-rating scale for depression, from Beck (Beck *et al.*, 1961); the patient is asked to read (or somebody else reads to him or her) a series of questions, for each one having to choose between the answers yes, no, and intermediate; the patient gets a score for each answer and a final score that bears on the intensity of the depressive syndrome, and which, if repeated, gives the orientation of its changes in time.

11. A methodological problem of different psycho-pathological questionnaires consists in the way the answer is requested (Lyerly, 1978). The most simple formula is the disjunctive one, the patient having to choose between yes or no. Some questionnaires use five positions, i.e. three variants between 'entirely true' and 'entirely false'. Another method consists in asking the subject to place his answer at a certain point on a line whose extremities are yes and no. Surely, there are also questionnaires with free discursive answers.

Standardization of psycho-pathological interviews must not take the place of the synthetic thinking of the doctor. He or she can get satisfactory information using only three or four questions with proper answers. But this should not take the place of complete structured interviews or specialized questionnaires, whose importance is stressed.

12. Another type of question appears at the same time with the use of projective psycho-diagnostic tests and psychotherapy.

12.1 In the case of some projective tests application, such as Rorschach (1921) or Murray (1943), the psychologist doesn't ask questions to which there are no direct or indirect verbal answer. He asks, for example: 'What can you see in this picture?'. The answer is an opportunity for interpretation in accordance with an interpretative theory.

The results of projective psychological tests do not directly present elements for a psychiatric diagnosis, but they permit the clinician to answer some questions regarding the patient and to shade the answers (Carr, 1968).

12.2 Within the framework of psychotherapies, the questions aren't put directly either, and the answers don't take part directly in the diagnosis. In individual psychotherapy the interrogative attitude of the doctor and his or her analytical interpretation is more important. The questions are almost always open. In group psychotherapy and in psychodrama the questions make a dialogue that can supply useful information for diagnosis which can be expressive for the person. All these participate in the understanding of the patient and even in trying to elaborate an interpreted psycho-pathological diagnosis which is different from a clinical one.

13. Finally, psychiatrists are both doctors and anthropologists. They are not interested only in questions like: 'What disease does the patient suffer from?', or 'How can it be treated?', but also: 'Who is the person *x*?', 'What is his way of being in the world, his actual existential moment, his possible destiny?'. To such questions the answers are more complicated.

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